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VETERANS' ADMINISTRATION AND DEPARTMENT OF LABOR'S VETERANS EMPLOYMENT AND TRAINING PROGRAMS, FISCAL YEAR 1987 BUDGETS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

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FEBRUARY 20, 1986

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VETERANS' ADMINISTRATION AND DEPARTMENT OF LABOR'S VETERANS EMPLOYMENT AND TRAINING PROGRAMS, FISCAL YEAR 1987 BUDGETS

THURSDAY, FEBRUARY 20, 1986

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SR-418, Russell Senate Office Building, Hon. Frank H. Murkowski (chairman of the committee) presiding.

Present: Senators Murkowski, Specter, Denton, Cranston, and Rockefeller.

OPENING STATEMENT OF CHAIRMAN MURKOWSKI

Chairman MURKOWSKI. I call the committee to order. I wish you all a good morning and welcome you to the Senate Committee on Veterans' Affairs hearing on the proposed fiscal year 1987 budget for the Veterans' Administration and for the Department of Labor's Veterans Employment and Training Program.

Ladies and gentlemen, this is one of the first days of reckoning, as we reflect on the realities of the budget reductions that are coming as a result of the Gramm-Rudman-Hollings legislation.

Among my colleagues, the support in the committee for Gramm-Rudman-Hollings, while not unanimous, was significant inasmuch as it represents an understanding that if we are going to take care of not only the obligations we have for the veterans in this country, as well as all of our obligations, we are going to have to put our fiscal affairs in order. That is much easier said than done, but that is reality.

I have looked through the statements of the various witnesses today. I certainly understand those representing various service organizations and their attitude. Their charge, obviously, is to seek the very best services that can possibly be made available to the veterans of this country. That is quite appropriate.

Those of us that represent veterans, the Veterans' Administration representatives at the witness table, and those of us in the Congress, will have to make do with whatever budgetary resources we are going to ultimately have as a result of the budget process. Unfortunately, in any case, that is not going to be enough, whether it involves veterans' benefits or whether it involves military preparedness. You can never possibly do enough, but we have to work with what we have.

So as we begin this process, I hope that you will share with me my concern over the realities that are with us. The realities that dictate that we must prioritize where we possibly can; that we ultimately are going to have a specific amount of budget resources; and these resources will have to go farther. We are going to have to increase efficiency. To just say more, more, more; or the obligation is here, here, here is fine. However, it is just not going to work because, in reality, we are going to have some budgetary cuts. If we who are involved with veterans programs do not take those cuts, we cannot expect other agencies to take those cuts.

By 1990 if there is not an effort to turn around this deficit, 40 cents out of every tax dollar will be interest on the debt. That is a sobering fact. If we do not take the necessary steps now, we are not going to be capable of meeting our obligations to the veterans of this country, or meeting our obligations concerning other necessary areas within the Government.

On behalf of myself; Senator Cranston, the distinguished ranking minority member; and all the committee members; we welcome Mr. Ev Alvarez, the Acting Administrator of Veterans' Affairs, and the witnesses who are with him today. Ev, you have certainly taken the wheel of the VA at the difficult budgetary time. That is often the case. I have great faith is your leadership and I look forward to your testimony.

I had an opportunity to meet with the new president of the American Petroleum Institute the other day who had just taken over that office. He said he had always hoped to have the honor of achieving that position, but at a time when oil prices have dropped by one-half in less than a month, he was not sure if he was the right person in the right place.

I commend you and I have great faith in your leadership. We all look forward to your testimony today.

I am pleased that Don Shasteen, the Assistant Secretary for Veterans' Employment and Training within the Department of Labor, is with us this morning to present the views of his department.

I also welcome the veterans service organizations' representatives who will be testifying. I look forward to your views and your recommendations on the fiscal year 1987 budget request. You represent the interest of many of our Nation's veterans and I welcome your perspectives on the important issues involved in the fiscal year 1987 budget request.

This year, Congress and this committee, once again, as I have indicated, take on the unwelcome challenge of balancing the competing interests involved in reducing the deficit—deciding which spending programs will be restricted and which revenue measures will be expanded to achieve deficit reduction.

This year will be different, though, because the full force of a sequester order under the Balanced Budget and Emergency Deficit Control Act of 1985 will come into effect if the Congress fails to reach a maximum deficit amount of approximately $144 billion for fiscal year 1987.

This enforcement mechanism was created out of frustration when the Congress could not resolve the impasse on how to achieve significant deficit reduction. I think you are all aware, as we are, that Congress did not have the self-discipline to address the deficit in any other way, and that is basically the rationale behind the so-called Gramm-Rudman-Hollings legislation.

It will greatly affect budget deliberations and decisions this year for the programs within all agencies, including the VA and the Department of Labor over which this committee has oversight jurisdiction. I might add that the entire leiglsative branch, as you know, is subject to the bite of Gramm-Rudman-Hollings. I hope that we in the Congress can make these decisions to achieve the savings so that a sequester order will not be triggered.

There are numerous options available, each of which presents its own controversy. Should deficit reduction be achieved strictly by reduced spending? And, if so, how will the reductions be allocated? Should increased spending for a strong national defense be accompanied by corresponding reductions in funding of domestic programs? Or should increased revenues, perhaps by increased taxes, be a part of the solution? As you and I know, there are no easy answers.

Last year I asked for your cooperation to ensure that by working together, we could protect the benefits of those who have borne the battle and their survivors, while at the same time striving to restore fiscal stability to the Federal Government. I reiterate that request again this year when the funding for every agency and every spending program will be scrutinized even more closely than in the past.

I am deeply committed to achieving deficit reduction. Let there be no doubt, though, that I am equally committed to securing a reasonable and adequate funding level for veterans' programs in fiscal year 1987 so that veterans' benefits and services will continue to serve the needs of our Nation's veterans.

Last week, I had an opportunity, with Tony Principi, my committee staff director, to meet with many of the veterans' groups in my State of Alaska to exchange views and recommendations with regard to Gramm-Rudman-Hollings and the veterans' budget for fiscal year 1987. I came away with a greater appreciation of those veterans' concerns. The vast majority support the Gramm-Rudman-Hollings concept from the standpoint of the need to reduce the Federal deficit. They only ask to be treated fairly and equitably with all other Federal programs, including defense.

The administration's fiscal year 1987 budget for the VA requests budget authority of $26.6 billion and outlays of $26.4 billion. These levels are less than the fiscal year 1986 levels of $27 billion budget authority, and $26.5 billion outlays after all adjustments. The net change from fiscal year 1986 is a reduction of $408 million budget authority and $186 million outlays.

When I first reviewed the Veterans' Administration budget request for fiscal year 1987, I was, I will admit, rather disappointed.

I certainly endorse reasonable attempts to reduce the deficit, as I said, but it appears that the administration's budget request for the VA was prepared without realistic consideration given to long-term planning and program integrity.

That is one of the areas I hope the VA witnesses will address this morning.

I concur with the concerns expressed by the veterans' service organizations in their opposition to certain major changes for the VA, such as unrealistic staffing reductions, increased home loan origination fees, and the premature termination of the new GI bill.

My goal is to report to the Senate Budget Committee an adequate funding level which will carry on the important programs and services of the VA and the Department of Labor.

I want to be very clear about this. It is possible to maintain quality VA care and benefits even in the context of constrained resources. It is our job—and yours—to prioritize programs and not to endorse any cuts that will adversely affect the heart of the VA.

I am pleased with some of the proposals and initiatives in the proposed budget such as the COLA for compensation, pension, and dependency, and indemnity compensation [DIC] recipients.

I endorse reforms in medical construction, which would achieve the legislative directive for hospital downsizing, and create more long-term care beds to meet the needs of our aging veteran population.

This budget also reflects a shift toward increased support for certain noninstitutional alternatives, a type of health care service delivery which I and the committee have long supported.

There is a request for increased funding for the congressionally mandated adult day health-care study, and for the increased use of hospital-based home care. I believe the VA should make the most of its existing authorities to provide, when medically appropriate, halfway house care for alcohol and drug-abuse treatment and for chronic mental illness disabilities.

I am concerned with and am inclined to oppose the overall funding reductions for reduced staffing levels within the agency until I hear the VA witnesses, who, I hope, will provide the committee with more insight on what the numbers really are and how the proposed reductions will affect the integrity of the VA system and the delivery of benefits and services to eligible veterans.

I look forward to hearing more on the modernization efforts and ADP initiatives, as well as the proposed reorganizations and how each of these would affect reduced staffing levels.

I strongly oppose the proposed increase in the home loan program's origination fee. I made my position very clear on this issue last year, and I repeat that I will not support a fee increase until I am convinced that all possible program reforms to strengthen the integrity of this program have been achieved first, and I really do not think that is the case as of this date.

We came very close to achieving these reforms in the waning hours of the 1st session, and you can be assured that will be one of my highest priorities.

I am surprised at the request to terminate the new GI bill in the 1st year of a 3-year pilot program. The program is off to what I consider a good start and in my view, it is somewhat shortsighted to anticipate terminating the program at this time.

I hope that those who support the termination of the program will share with the committee the justification for its termination, since I am not aware of any justification as to why the program should not continue.

There are, of course, many other major issues included in the budget request which I will not touch on now. Our purpose today is to gather the views and comments of the witnesses who are familiar with the operation and goals of the programs to be funded by the budget request and the needs for our Nation's veterans.

Before we begin today, I want to pause for a moment to recognize the Department of Medicine and Surgery. This marks the 40th year of the department's service to veterans.

On this anniversary, it is fitting that we pay tribute to the thousands of dedicated men and women who have devoted their lives to caring for our Nation's sick and disabled veterans.

Dr. Ditzler, as Chief Medical Director, I want to congratulate you on a job well done. I am truly sorry I could not attend the DAV reception in honor of the occasion last evening. I want to emphasize that I will continue to work with you, to protect this extraordinary system of quality health care and to resist efforts to erode the system by implementing monumental staffing cuts.

At this time, I want to call on my colleague, Senator Cranston, the ranking minority member. Senator Cranston, good morning.

OPENING STATEMENT OF SENATOR CRANSTON

Senator **Cranston**. Good morning, and thank you, Mr. Chairman.

I am pleased to welcome everyone for this morning's hearing on the fiscal year 1987 budget for veterans' programs. There are many issues of great importance and concern to our Nation's veterans and their families to discuss today.

Speaking plainly, I find this budget fundamentally flawed and grossly unfair to veterans. In terms of the VA's medical program, it is undoubtedly the worst budget submitted in the last 15 years.

This is the budget that OMB has been dying to submit for the past 5 years. It would warm the cockles of David Stockman's stone heart. How ironic that he has finally prevailed in the first Reagan budget for the VA that he did not draft.

Let me describe some of the low lights of this budget. For fiscal year 1987, the administration's medical care account proposal is $384 million, or 4 percent, below its current services estimate.

Accepting the administration's workload estimates, the VA would provide 58,000 fewer episodes of hospital care and 1,100,000 fewer outpatient visits than in fiscal year 1986.

The level of employment in VA facilities would be 8,848 FTEE less than the number, approximately 194,000, for which Congress appropriated funds for fiscal year 1985 and, prior to the Gramm-Rudman cuts, for fiscal year 1986.

Not considering the 1,307 FTEE provided for new activations, the cut in the current medical program is thus over 10,000 FTEE.

Let me note that the term FTEE is a very sterile concept. What is actually involved here, in human terms, is 10,000 fewer doctors, dentists, nurses, nursing assistants, therapists, psychologists, social workers, technicians, and other personnel providing direct care to sick and disabled veterans at existing facilities.

Beyond fiscal year 1987, the budget projects further FTEE reductions averaging 20,000 per year until in fiscal year 1991, the five-year total reductions from the fiscal year 1986 appropriated level of 194,000 would be approximately 90,000.

The attempt to "shrink" the VA medical system is also clearly evidenced in the major construction account request for fiscal year 1987, $301 million, which is over $200 million or 40 percent less than the amount originally appropriated for fiscal year 1986.

Proposals like these are totally unacceptable. We've worked too long and too hard to provide deserving veterans with a strong, high-quality health-care system to let this administration finally succeed in its efforts to begin tearing it down.

I also want to repeat my continuing, strong opposition to the administration's renewed proposal to increase the loan guaranty fee, first to 2 percent, and ultimately to 3.8 percent.

The destructive impact of such fee increases was well documented last year. Despite the administration's long-standing opposition to any new taxes or tax increases, what it is proposing here is, in essence, a veterans housing tax.

In partial contrast, the administration is being consistent in refusing to request any appropriation for the Veterans Job Training Act.

The administration has always opposed this successful program of great importance to veterans with long-term unemployment problems.

I will once again work for an appropriation for this program, noting that $55 million was voted by the Senate last fall but rejected by the House in the fiscal year 1986 continuing resolution.

I also find the proposal to reduce eligibility for the plot allowance unwise and unfair, and I will fight the counterproductive proposal to terminate the new GI bill.

Equally unsound and shortsighted is the proposal to break faith with veterans by selling off over $350 million worth of VA land in southern California.

Finally, I want to note my concerns regarding the administration's proposal to reduce funding for local veterans' employment representatives based on the determination that there are suddenly scores of local employment service offices in which LVER services are no longer required.

We must ensure that needed assistance for veterans seeking employment is provided.

I cannot agree with those who would make apologies for the administration's budget for the VA by claiming that these cuts are forced on it by the threat of across- the-board cuts under Gramm-Rudman.

There are two basic problems with that view. First, the administration had an entirely free hand in shaping its budget so as to bring in a deficit total not exceeding $144 billion for fiscal year 1987, the Gramm-Rudman target.

There is no requirement in Gramm-Rudman that veterans' health care bear a disproportionate share of the burden of deficit reduction or that a tax be placed on VA home loan guaranties—or, for that matter, that military spending be increased by 12 percent while veterans' programs are reduced by about 1 percent.

Indeed, Congress has given veterans' health care special protection under Gramm-Rudman.

Second, too many of the President's proposals are reincarnations of congressionally trashed propositions that this administration has put forward or supported during the past 5 years. Gramm-Rudman is the excuse, not the reason, for proposing them now as part of the President's formal budget request for fiscal year 1987.

For example, in March 1981, the administration proposed a $330 million cut in its proposed budget for VA medical care for fiscal year 1982. In May 1982, the administration supported a $568 million cut in the budget for VA healthcare accounts, including construction, that it had previously submitted for the fiscal year 1983 budget.

The loan guaranty fee increases are identical to those that the administration sought last year.

What is before us today simply indicates to me that those misguided individuals in OMB and the White House who wish to "shrink" the VA health-care system and to make whatever cuts they believe they can get away with in other veterans' benefits have once again gotten the upper hand and believe that Gramm-Rudman provides good cover for pursuing their antiveteran goals.

I am committed to ensuring that they do not succeed. Those are the individuals who refuse to recognize that the costs of veterans' programs are a continuing cost of defending our Nation in wars past and of maintaining our national security.

I call on my colleagues on this committee to join with me in fashioning a fair budget for veterans' programs.

We must, in light of the great need to reduce the towering Federal deficit, exercise prudence and restraint in making our recommendations. Indeed, we've already pared VA spending through the budget process by over $2 billion through fiscal year 1986, and the reconciliation legislation developed by the Veterans' Affairs Committee last year would have added savings of another $1.3 billion for 1986, 1987, and 1988.

But we must not break faith with those who served, and we must not permit the VA health-care system to be whittled down.

Before closing, I want to note one piece of good news. The committee is proceeding to move ahead with the bill, S. 2052, I introduced with the chairman and other committee members on February 5 to protect the home loan guaranty program from the devastating blow it would receive under Gramm-Rudman as a result of the faulty estimate of loan guaranty activity used in the President's order putting in a fiscal year 1986 limit on the program.

I am grateful to the chairman for his cooperation and support in this matter and hope that we can obtain swift Senate passage and enactment of this badly needed corrective measure.

Thank you. I look forward to hearing today's witnesses and reviewing the testimony.

Thank you very much, Mr. Chairman.

Chairman MURKOWSKI. Thank you very much, Senator Cranston.

Senator Denton, have you an opening statement that you would like to make?

Senator DENTON. Well, I will wait until you have the first testimony here.

Chairman MURKOWSKI. All right.

Senator DENTON. Thank you very much.

Chairman MURKOWSKI. Thank you very much, Senator Denton.

Our panel consists of Mr. Everett Alvarez, Jr., Acting Administrator of the Veterans' Administration, who will be accompanied by Mr. Donald Ivers, General Counsel; Mr. Conrad R. Hoffman, Director of the Office of Budget and Finance (Controller); Mr. Raymond J. Vogel, Chief Benefits Director; and Dr. John W. Ditzler, Chief Medical Director, Veterans' Administration, Washington, DC.

Mr. Alvarez, I think, it is particularly noteworthy, that you, as Acting Administrator, are again before us. Having had an opportunity to visit Hanoi not too long ago and recognizing that you were one of the very first American pilots to have been shot down over there, and acknowledging your long term in captivity, I can appreciate the price that you paid for freedom and I certainly commend you. It is an honor to welcome you here before us today, in your capacity as head of the largest health-care organization in the free world. It is a tremendous responsibility that you have in this capacity. Recognizing the way the administration review process works, the input of OMB in the budgetary process is not necessarily representative of your own desires.

I understand that. I look forward to your comments and recommendations, and I will have questions for you and your colleagues.

Again, I want to welcome you to the committee, and you may proceed with your statement.

Mr. ALVAREZ. Thank you, Mr. Chairman.

I'd like at this time to submit my prepared statement for the record, if I may, and——

Chairman MURKOWSKI. It will be admitted in the record.

[The prepared statement of Mr. Alvarez appears on p. 73.]

STATEMENT OF EVERETT ALVAREZ, JR., ACTING ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION, ACCOMPANIED BY DONALD L. IVERS, GENERAL COUNSEL; CONRAD R. HOFFMAN, DIRECTOR (CONTROLLER), OFFICE OF BUDGET AND FINANCE; RAYMOND J. VOGEL, CHIEF BENEFITS DIRECTOR; AND DR. JOHN W. DITZLER, CHIEF MEDICAL DIRECTOR

Mr. ALVAREZ. My testimony today will be a summary of that statement.

By the way, you didn't happen to see a pair of shoes I left behind back there did you? Saddles.

Chairman MURKOWSKI. No, I wasn't looking for shoes. [Laughter.]

Mr. ALVAREZ. Mr. Chairman, members of the committee, I'm grateful for the opportunity to appear before you today to discuss the Veterans' Administration's 1987 budget.

As we are all aware, Public Law 99-177 requires a balanced budget by 1991. Actions to achieve this long-range goal are already being taken in 1986.

As you also know, the 1987 package is formulated to meet the deficit target of $144 billion without raising taxes. The fiscal year 1987 budget request of $26.6 billion reflects the VA's share of that plan.

You will note that the medical care budget reflects a shift in long term care policy, calling for increased resources for noninstitutional care and for VA supported State and community nursing home care programs. Within our medical centers our budget reflects greater emphasis on conversation to nursing home beds.

Agency-wide this budget reflects our continuing emphasis on modernization, a program which is the key to our future operations. This can be described as a tough budget, but for the VA that means that we have to try in earnest to get the most out of every dollar.

We are fully aware that the VA programs fulfill real needs, and our obligation to carry out effective programs has not diminished in any way. We will continue to provide quality care to our veterans who deserve no less.

We believe it's important to point out that the VA has once again been treated fairly in the overall distribution of resources. We are pleased that the Congress and the President have exempted three major VA programs from some of the effects of Gramm-Rudman.

Compensation and pension are entirely exempt from sequestering, and the medical care account has been partially protected. We're convinced that these exemptions represent a strong commitment from both you and the President to provide to America's veterans the benefits that they've earned.

Mr. Chairman, with respect to the current fiscal year, there was great concern expressed about the VA's gross underestimation in the level of loan activity in the Home Loan Guarantee Program due to the low interest rates and a strong economy.

In view of the fact that soon the VA would not have sufficient authority to accommodate all applicants, we greatly appreciate the assistance of yourself, Mr. Chairman, and the ranking minority in addressing the problem so expeditiously.

To provide the additional credit authority needed and remaining fully committed to the Gramm-Rudman-Hollings law and its deficit reduction targets, the VA supports an increase in the loan commitment ceiling, coupled with an increase in the loan origination fee to 2 percent as proposed in the fiscal year 1987 budget submission. In doing so we remain committed to meeting the 4.3 percent target under Gramm-Rudman-Hollings.

If I may, I'd like to address for a moment the affects of the fiscal year-1986 sequestering. Public Law 99-177 will affect readjustment benefits, burial benefits, and insurance programs. Education payments under the GI bill and payments for vocational rehabilitation and dependents education assistance will decrease. Plot allowances and burial benefits will also be reduced.

The insurance programs will be affected by cancellation of the previously scheduled loan interest rate reduction. We are considering a variety of options to achieve necessary staff reductions.

In addition to attrition, certain reprogramming actions should help us. We plan to reduce cash awards, employee travel, and equipment purchases to the extent necessary to avoid adverse personnel actions. These steps will be closely monitored within the agency. In doing so we intend to redistribute any savings realized to those offices having the most difficulty absorbing the reductions.

Reprogramming is anticipated between GOE—DVB, and GOE—General Administration. Certain benefits accounts will also be considered for reprogrammings, as will some medical and construction activities.

We believe that these actions will enable us to meet the required reductions, avoid adverse personnel actions, and still maintain a high level of service to veterans.

Chairman MURKOWSKI. Mr. Alvarez, I wonder if you could pause for a moment? My colleague, Senator Specter, has to leave and he wants to submit a few questions for the record.

Senator SPECTER. Thank you very much, Mr. Chairman.

I appreciate the opportunity to say just a word.

First, I commend you for holding these important hearings. I regret that I cannot stay, but the Judiciary Committee is meeting at the same time, so I very much appreciate leaving some questions for the record.

Chairman MURKOWSKI. I will be happy to include these in the record and present them, and I thank you.

[The questions and responses appear on p. 868.]

Senator SPECTER. Thank you, Mr. Alvarez.

Chairman MURKOWSKI. Please proceed.

Senator DENTON. Mr. Chairman, since we took that break, I would like to extend your patience and that of our Acting Administrator further. I am prepared to make a statement.

I have an interview as well as this Judiciary Exec to go to. Otherwise, I would stay for the whole meeting.

Chairman MURKOWSKI. Please proceed.

OPENING STATEMENT OF SENATOR DENTON

Senator DENTON. I also salute Everett Alvarez. He was indeed the first American pilot shot down in North Vietnam and there is no one I admire more for the manner in which he conducted himself during—over—the 8 years in captivity there.

I remember one time I was allowed to exercise in a yard. It was the first time that I was allowed to really maneuver around. It was about half as big as this room. I'd heard of Everett Alvarez. Apparently he'd been exercising in there during the year, almost 11 months before I was there, and he had left little sayings around like "Happy Halloween, Merry Christmas." Little American things that he was saying to no one that he knew to be around. Then in one place, I found a saying he'd written up there, "Lord, I am not worthy that thou shouldst come to me. Say but the word and my soul shall be healed," which was fairly well indicative of the way all of us became under those circumstances.

So, we share a bond and I respect him very much, and I know he's also very able. I'm glad that he's Acting Administrator now.

I, too, am a veteran with 34 years total service—31 commissioned. I hope the veterans realize that I will listen because I am one of them and I know and I care. And, frankly, I'm being accused of being against veterans.

One thing I should let Mr. Alvarez know. My wife came to me the other day and said that at a POW—Alabama ex-POW's convention in my State, Ev said that I hadn't voted for certain things regarding POW's because I would consider it self-serving, and indeed I think there was a vote on which I did that. I know you meant it well, but they didn't take it well. My wife said the lady was weeping when she told her about that.

So, here I find myself in a very incongruous position with two veterans' organizations heavily down on me, maybe three. So, I'm going to have to try to correct the impressions and also the political position for my own self-serving interest, but I think also in the interest of honesty and truth on the matter.

I would say that I want to press on Mr. Alvarez again a specific way that we could save money and provide more medical services to our veterans than we are otherwise going to be able to do; that is, if the Veterans' Administration will see fit to listen to the order they have received long ago to buy existing facilities for use in providing medical care to our veterans.

Some of my colleagues have teased me because the example I chose to foist upon everyone happens to be a hospital that is in my hometown and up for sale, one which was found by the VA inspection team to be suitable for veterans' care.

The hospital is not in the precise geographic center of the veterans' population down there, but it's close enough to it, in my view, and I want you to know, Ev, that when veterans came to me about that hospital, I told them that there's no way I was going to try to sell that hospital to the Veterans' Administration.

It seemed to me like all they wanted me to do was represent my constituency in Alabama, and so forth. It took me about 4 months to be convinced that they really had something that I should sell, so I tried to sell it. I've been, for some time, urging the VA's serious consideration of acquiring that hospital in Mobile, AL, and many of my colleagues have seen the merit of the proposal.

Unfortunately, the VA has not been willing to give the opportunity—in my view, the serious consideration it deserves. Yes, there are all kinds of forms you can out and cases you can make, but the point is the VA has never bought an existing hospital because down deep, they believe, as many of us here in Congress do, we're going to feather a nest for our own good.

The VA Administration people in the various States have their ways of being helpful. They are perceived as good careerists and so on, so it somehow behooves them, in terms of support for the VA, to go ahead and buy a new hospital. The real estate guys make out, those who own the land make out, the construction people make out, and the lawyers who handle the thing and handle the sale make out.

In the meantime, the veterans suffer because not once have we found it possible to buy a good existing facility that is found serviceable by the Veterans' Administration's own team. I'm going to press the merit of that proposal constantly, and if you want to call it political, fine; we'll see who wins that battle because it's not political. I believe you're not doing what you've been told to do. That way I think it's costing our veterans and we have a large population of them in Alabama who are quite indignant about that. I've got to bring it up now as I welcome my friend because it's a matter that is of very great interest to me and I think to veterans everywhere.

I'll close and summarize the rest by saying the current issue of the DAV Magazine has a very interesting interview with the former Veterans' Administrator, Harry Walters. In it, he makes four points which I wish to address.

The first is how frustrating it is to be the Administrator of the Veterans' Administration when Congress is micromanaging that agency. I'll acknowledge that the Administration should have more control, but Congress has more than an appropriation responsibility. It also has a policy responsibility and that—the policy that I just referred to—is one which we're supposed to be ensuring is enforced. It hasn't been enforced by the Veterans' Administration.

The second point Mr. Walters makes is that 'when all is said and done' Congress treats the veterans and VA more favorably than almost every other agency. Well, I'll say to that that they sure as heck ought to. Those guys did their service. It's not like a business. They took their risks. They signed up. It's the most sacred dedication on which they could embark and I don't see why we shouldn't treat them better than we do any other agency.

This year, the VA, according to Mr. Walters, may be, as a matter of fact, better off than Defense. Well, in my view, neither Defense nor VA is going to be very well treated with Gramm-Rudman. They're talking about an 18 percent drop in Defense appropriations in 1987 instead of a 3 percent increase as Congress promised the President.

I think that would be a debacle. The President has been given for just this year a chance to talk about what he's going to do within certain sectors of the budget. After that he's not going to be able to protect anything, and then we're going to be up against the problem.

I know that Mr. Alvarez and everyone else in the Veterans' Administration is going to be suffering, trying hard to find ways to pull the VA through.

I admire Mr. Walters very much. I think he did a good job in the agency. He is a distinguished veteran by his own right. I will submit the rest of this for the record, Mr. Chairman.

While we can't give everything to everybody, I think we've about reached the point where we can't afford to be any more squinchy with our veterans than we have. We start with the armed services and then we cut those pies. Congress is going to find it stupidly motivated because those are volunteers out there. We're already losing pilots by the scads in spite of the fact that they're being given a big reenlistment bonus' but they're just going to learn that it's going to cost them more money the other way. They're going to have to go to a draft or something which will be more expensive.

And, to take it out on the veterans who have no power other than their deserts, their worthiness, is something that is despicable as a prospect to me. I don't think it has happened in any material way, and I've admired both Senator Simpson and Senator Murkowski, as chairman, but it is a mixed picture and one about which I have many frustrations. I implore Mr. Alvarez, if he finds it in his heart to correct that misimpression down there because it's a major thorn in my side right now and I don't think you meant it that way, Ev.

Mr. **Alvarez**. Senator Denton, I never made any statement with regard to any vote that you have said, and if you heard that, I'm sure I was misquoted or was misrepresented in some way.

Senator **Denton**. OK. This was a lady who thinks that my wife and I are great and she went to an Alabama POW group. I don't know whether it was State or not. And, it is true that once I said something about that I have to push this or that because I am a POW. I am a veteran.

It may be that once I didn't vote on something because I said it would appear to be self-serving, but it was something that was going to pass anyway and you would have been one of the only people to know about that or somebody in the committee. And I said to my wife, "I know Ev didn't mean it that way. He didn't mean to criticize me in any way," and I'll try to find out more about that incident for you, but the lady would have no way of hearing something in error. Nobody could have made that up. But, we'll straighten it out, I'm sure.

Mr. **Alvarez**. Please, sir.

Senator **Denton**. Thank you, Mr. Chairman.

Chairman **Murkowski**. Thank you very much, Senator Denton. As you have pointed out, you share Senator Cranston's and my conviction that we have a very difficult situation before us.

You, Senator, in your former military capacity during 7 years of captivity in Vietnam have also paid an extraordinary price. I think it is truly notable that both you gentlemen continue to serve your country in an outstanding manner with extraordinary contributions.

I think your objectivity, collectively and individually, is most significant as we reflect on our obligation to American veterans, and you, Senator Denton, have always been known for speaking your mind. Your forthright attitude prevails within this committee and we are very pleased with that. I wish you a good day as you depart for the Judiciary Committee.

Mr. Alvarez, in order to accommodate the significance of your testimony, I intend to allow you whatever time you need for your statement. I recognize you began to go through it. You were interrupted a couple of times, but I do want to extend the courtesy of permitting you to proceed and make whatever points you desire.

Prior to doing that, however, I would like to accommodate the rest of my colleagues on the committee and I would call on Senator Rockefeller for a statement at this time.

Senator, we have heard from our colleagues, both those who have supported Gramm-Rudman-Hollings, which is one reason why we are here today, and those who opposed Gramm-Rudman-Hollings. It is your turn to make a statement if you have one.

Senator **Rockefeller**. I do have one and I'll insert it in the record and listen to——

Chairman **Murkowski**. Fine.

Senator **Rockefeller** [continuing]. And I voted right down the middle.

Chairman **Murkowski**. Well, that's kind of tough to do sometimes.

Thank you very much, Senator Rockefeller. Your entire statement will be entered into the record as if read.

[The prepared statement of Senator Rockefeller appears on p. 69.]

Chairman **Murkowski**. Mr. Alvarez, you may proceed as you see fit, and I do apologize for the interruptions. It is my intention not to interrupt you again.

Mr. **Alvarez**. Thank you, Mr. Chairman.

Let me continue to highlight the Veterans Administration's 1987 request which calls for $26.6 billion in new budget authority.

The largest portion of the budget request continues to be for our benefit programs, which at $15.4 billion constitute 59 percent of the total. Proposed legislation in this area calls for a 3.7-percent cost-of-living increase for compensation and pension recipients to be effective December 1, 1986.

The medical care budget of $9.1 billion shows a decline of $44 million from the 1986 level, which was adjusted to reflect the impact of Public Law 99-177. Medical care employment is projected to decline 7,542 from the 1986 level of 192,635.

Even with these reductions the budget will provide for treatment of approximately 1.4 million in-patients and over 18.6 million outpatient visits.

The VA will continue to meet the demand for quality medical care for veterans who are service-connected or who have low incomes.

Our ability to meet that demand effectively and equitably requires some refinement of eligibility criteria. In the past Congress recognized the need to legislate a set priority system for provision of VA medical care.

It is once again time to focus on just what criteria should apply and in what order.

We have given this much thought and our conclusions are embodied in two legislative proposals. The basic thrust is to give more weight to financial need than to age in the case of nonservice-connected veterans.

One new legislative proposal would remove age as a determinant in eligibility for medical care and establish income guidelines to measure financial need. Use of the VA medical system would be restricted for most nonservice-connected veterans whose income exceeds twice the VA pension level.

Legislation is also included to obtain third-party reimbursement in the case of insured veterans with non-service connected disabilities. Reimbursements for 1987 are estimated at $187.5 million.

The general operating expense request is for $763.5 million and 18,337 average employment to operate the Department of Veterans Benefits, the Department of Memorial Affairs and various staff functions in central office.

The modernization effort which was conceived last year will have its first full year of implementation in 1987. The Department of Veterans Benefits will take over responsibility for ADP development for their programs and the corresponding 362 positions will be transferred to DVB from the Office of Data Management and Telecommunications.

We have also included a proposal to close the St. Paul Insurance Center, transferring its workload to Philadelphia. When completed in 1988 the transfer should result in recurring annual savings of $1.3 million.

The 1987 request for the two construction appropriations total $408.2 million. A program level of $465.2 million will be supported with $57 million available from previous appropriations. Included in the request are 10 major projects and medical facilities. The projects range from full funding for replacements at Baltimore and Augusta, to initial funding for modernization at Dayton and north Chicago.

The construction program continues to emphasize correction of life, safety and other code deficiencies. This budget also contains a proposal to transfer to the Chief Medical Director responsibility for the agency's construction program.

To accomplish the reorganization, 73 positions would be moved from DM&S Facility Planning under the MAMOE appropriation, to the Office of Facilities, formerly the Office of Construction which is under the construction appropriation.

Mr. Chairman, this concludes my statement. We have recently received many questions which were submitted to the Agency. We are in the process of answering these questions, and at this time my staff and I will be pleased to answer any of your questions.

Chairman MURKOWSKI. Thank you, Mr. Alvarez.

Are there any other statements that will be made by your panel?

Mr. ALVAREZ. No, sir, that concludes the statements to be presented this morning.

Chairman MURKOWSKI. Tell me a little bit about the fiscal year 1986 estimate of home loan activity. Evidently, there was a difference of opinion of approximately $6 billion.

It is my understanding that you announced plans to implement three programmatic changes to the Home Loan Guaranty Program. They would have included a termination of refinancing, elimination of partial or restored guarantees, and a maximum loan limitation of $90,000 on new loans.

Last night the policy was reversed, and the VA announced that in light of the legislation which Senator Cranston and I and other members of the committee introduced to alleviate the credit limitation problem, that you will not need to cut back on any home loan program benefits.

Could you put this in some kind of a perspective for us because we still have some confusion.

Mr. ALVAREZ. Mr. Chairman, I will let Mr. Vogel answer this in detail, but initially we had looked at some of the options that we felt were available to us in order to meet the requirement.

When we had our hearing at the House, these options were announced as things under consideration, steps that would be taking place, effective March first of this year. It was subsequent to that that we then learned we would not be able to take a couple of those steps—refinancing and restoration of eligibility.

Given the situation, it looked to us that we would reach the limit of our commitment authority very soon, and at that point announced our intention to continue with the program without restrictions until reaching out limit, but looking forward to legislative relief.

I will let Mr. Vogel get into more detail. Mr. Vogel runs our Department of Veterans Benefits and has responsibility for that program.

Chairman Murkowski. You needed an increase in credit authorization from $12 billion to $18 billion, is that right?

Mr. Alvarez. That is correct, sir.

Chairman Murkowski. Is that sufficient?

Mr. Vogel. Mr. Chairman, we believe that will be sufficient. When the estimate was first made, the interest rates were 2 full percentage points over where they are now. The economy is now better; the interest rates are down to 10.5 percent. The initial estimate that approximately $12 billion in total loan amount would be sufficient was postulated.

That figure is based on approximately 180,000 loans for this fiscal year. At the current rate, we will guarantee about 270,000 loans. We believe that, at that rate, the $18.2 billion in total loan amount will be sufficient to provide the benefit to all veterans.

Chairman Murkowski. With the interest rates coming down, refinancing is going to occur.

You have taken that into account?

Mr. Vogel. Yes, sir, we have.

Chairman Murkowski. You feel quite comfortable with that?

Now, concerning the loan guaranty, there is no appropriation necessary there?

Mr. Vogel. No, sir.

Chairman Murkowski. Because that is just a contingent liability, so to speak. The Government may be called upon, but——

Mr. Vogel. And it may not be called upon until 1987, 1988, 1989, as the case may be.

Chairman Murkowski. Yes.

Is it your understanding then that the VA is back on line with this program, assuming that the legislation is signed into law?

Mr. Vogel. Yes, sir.

If that should happen, we are back in business, sir.

Chairman Murkowski. There has been some confusion on our part and there may be some confusion on behalf of veterans represented through the veterans' organizations. If there are any questions that we have yet to resolve on this matter, I would hope that while we have this hearing process continuing today, that the VA representatives can remain with us while the representatives from the veterans' organizations testify, so that if they have anything on this Home Loan Guaranty Program, we can address and hopefully resolve those concerns.

I can assure you that we will pursue this legislation next week and get it up on the floor and moving forward.

In your testimony, you stated that in the context of the fiscal year 1986 sequester order, the VA, in relation to other Government agencies, has again been treated fairly in the overall distribution of budgetary resources.

How do you generalize that statement with regard to the VA's fiscal year 1987 budget request, and what is the basis for your opinion? Also can you tell me which departments and agencies have fared better than the VA?

Mr. ALVAREZ. Mr. Chairman, in my statement, I felt that, because the compensation and pension programs have been exempted and the impact of Gramm-Rudman on our medical care account had been limited, the 4.3 percent of reduction in other areas was fair and equitable in comparison. With respect to 1987, with respect to how the VA forced with other Federal departments and agencies, I don't have that information available.

However, we could submit it for the record if that is your desire.

Chairman MURKOWSKI. I think you have explained your position with compensation, pension, medical care, and the safety net for those programs. When you say 4.3 percent, I am reminded of our own dictate internally within the Senate where we have initiated a 4.3 percent reduction in our overall budgetary process. It really amounts to about 10 percent, both for the professional staff here on the committee, as well as our own individual offices, and we are unfortunately cutting personnel.

How much of an adjustment was made by OMB to the VA budget for fiscal year 1987 in order to accommodate the increased defense budget and still remain within the minimum deficit amount of $144 billion?

Do you know offhand?

Mr. ALVAREZ. Offhand, I think the adjustment to our budget request was about $1 billion.

Chairman MURKOWSKI. About $1 billion. Thank you.

In a written response to a follow-up question after last year's budget hearing, there was a statement made by the VA that the disadvantage of the across-the-board reductions is that they could "strangle the system as a whole."

Do you believe that the $504 million reduction of close to 9,000 full-time staff would "strangle" the VA medical care system, and, if not, why not?

You indicated in your statement that you were looking toward attrition to take care of some of that.

Mr. ALVAREZ. Mr. Chairman, the 9,000 decrease, does that include the one, the 1,300 increase that we experienced this year?

Chairman MURKOWSKI. Yes, it does.

Mr. ALVAREZ. John.

Chairman MURKOWSKI. Dr. Ditzler.

Dr. DITZLER. I think the answer to your question is that it makes it much more difficult for me to manage but it is manageable. It is manageable primarily because of our intent to reduce workload rather than reduce quality.

With a reduced workload, we believe the ratio of dollars and FTEE to workload would remain essentially the same, and that we could still provide a quality product.

Chairman MURKOWSKI. Could you explain for the committee the fine line between reducing the workload and maintaining the quality? Do you increase efficiency? Is that what you are, in effect, saying?

Dr. DITZLER. In general, the greater the workload, the more people you need to take care of it. So if the dollar is the governing force, and you reduce the number of employees, but do not reduce the workload, you will reach a point of efficiency beyond which you cannot deliver a quality product.

Chairman MURKOWSKI. Well, how do you do this without treating less veterans?

Dr. DITZLER. You state in the beginning that we will probably be treating fewer veterans. We are certainly indicating we will be providing a million fewer outpatient visits.

Now, how many veterans that represents is problematical. It may be that there is a direct relationship to the number of veterans; it may not. The probability is that there will be fewer veterans treated.

Chairman MURKOWSKI. I think that your statement assuring the committee, based on your own reputation, that the VA will continue to provide quality medical services, is one that the committee as well as the service organizations will be reflecting on. The concern, obviously, is one of maintaining a continued capability in quality, and when you indicate that by reducing the workload you can continue to provide quality care with a 9,000 reduction is certainly meritorious. I think that reflects upon your own commitment and that of the VA that you feel you can do the job.

Tell me what is the general attitude and, I guess, I might use the word "esprit de corps" within the VA, as a consequence of a possible staff-reduction of 9,000 in the Department of Medicine and Surgery?

Dr. DITZLER. I believe the esprit de corps of the Veterans' Administration health system is excellent. I think the group of people in the VA are a dedicated group of people. I sincerely believe that. They do not like cuts any more than anybody else; but I think we will shore up deficiencies, and I think we will be able to do it.

We will have to admit we are going to provide fewer outpatient care visits and treat fewer inpatients. I think that is the only way that we can continue to provide a quality product.

Chairman MURKOWSKI. If you were given "carte blanche" to reduce the VA medical care programs by $500 million, or thereabouts, where would you set your priorities?

Would you reduce staff or close programs or facilities? How would you choose to find the savings?

Dr. DITZLER. Well, part of the reduction, as mandated by the President's budget is in a productivity reduction of some 1,939 employees. I propose to take that across the board in every hospital, every medical facility, and to take that primarily out of administrative efforts.

If the loss related to workload decreases is taken across the board, I think major mission changes would certainly be mandated.

Some small hospitals that have small surgical programs are going to have to stop doing surgery and transfer those patients to larger, better equipped and better staffed hospitals. We are going to have to decrease the total number of tertiary level facilities by making referral centers out of those that are the most efficient and create more referral centers.

Chairman MURKOWSKI. I have used my ten minutes, and I am going to defer to Senator Cranston.

Senator CRANSTON. Thank you very much.

First, I want to state my extreme disappointment and dissatisfaction with the VA's failure to provide any answers at all to the prehearing questions that I submitted to you.

Those questions arrived in the VA central office on the morning of Monday, February 10, which was a full ten days ago.

In my cover letter to the Acting Administrator, I specifically requested the courtesy of a response by Tuesday, February 18, and asked that if only some of the answers were available at that point, a partial response be provided.

I cannot understand why, in good faith, not a single answer was provided.

Everett, could you tell me why and how it happened that in 10 days you could not answer one single question? The problem is that when we do not get the written answers, then we have to sit here and go through all of those verbally with you.

Mr. ALVAREZ. Senator, I can assure you that our staffs were working as hard as they could to get the answers up to you through OMB. At this point, I think we have responses already at OMB. The difficulty we had was that there were over 400 questions that we received, and some were extremely complex. It took quite a bit of time, and I apologize that we did not get any to you beforehand.

Senator CRANSTON. I presume——

Mr. ALVAREZ. Sir, I have no excuse.

Senator CRANSTON. I presume the hangup was in OMB rather than in VA.

Mr. ALVAREZ. Well, there are some questions over there now, sir. I do not know how many, but others are on the way now.

Senator CRANSTON. In order to get questions from you that do not bog down in the morass in OMB, we have to ask you directly here, I guess, to get a VA response, rather than an OMB response.

I hope the agency is prepared to respond to the questions now, and I will ask some of them again, at this point.

As you know, the committee has a February 25 deadline for submitting budget views and estimates to the Budget Committee; so we have our own severe time constraints in trying to be educated when we act.

Do you think that we can get most of the answers today or tomorrow to the written questions?

Mr. HOFFMAN. Senator, we understand that OMB is now reviewing the questions that were sent over the day before yesterday; and, hopefully, we will be able to get responses back to you by tomorrow.

Senator CRANSTON. By tomorrow.

One other point, when will I receive a response to my February 5 letter to you, Ev, asking specific questions about the implementation of the Gramm-Rudman March 1 sequestration order.

Mr. ALVAREZ. Mr. Hoffman, would you answer that?

Mr. HOFFMAN. I am told that is also at OMB, Senator.

Senator CRANSTON. Do you know when it will get out of OMB?

Mr. HOFFMAN. When we leave here, we will pursue it closely.

Senator CRANSTON. If you could get it to us by the end of today, the latest tomorrow, I would be grateful to you.

Mr. HOFFMAN. All right, sir.

Senator CRANSTON. As I have said, I am deeply concerned for a variety of reasons about the drastic cuts that are proposed in the budget for the medical care account. The VA's own most recent survey of veterans' demand for care found that during the survey week in April 1985, the agency was unable to provide needed care to nearly 9,000 veterans who needed that care.

This survey made no finding about the suppressed demand for care, a phenomenon that many knowledgeable observers are certain exists, particularly in those regions of the country where the VA has been turning away large numbers of veterans who were seeking care.

Dr. Ditzler, do you agree there is something that amounts to suppressed demand?

Dr. **Ditzler**. The study to which you refer clearly did indicate that during a given week, in all of our facilities nationwide, there were approximately 9,000 veterans, who turned to other resources other than the VA.

The difficulty with that particular survey, in my opinion, is that it is deficient in defining the exact reasons. The reason given in some cases, for example, was simply lack of resources.

To further define that, we went to the field to find out details on at least a thousand of those, and we found that the survey questionnaires did not identify anything other than lack of resources. We now know that in some cases it meant that they could not award a followup clinic appointment for a period of 30 days.

In other cases, where, for example, an elective operative procedure, such as a total hip replacement was required, there was no room on operative schedules for a period of 10 or 11 months so that the definition of why they were turned away is suspect.

We do have to admit that there were 9,000 during that week.

Senator **Cranston**. What I was really trying to find out is not about that 9,000; but is there such a thing that is referred to now as suppressed demand, where people do not even seek services because they know it is hopeless and they are going to be turned away.

Dr. **Ditzler**. My planners talk about suppressed demand all the time, but it is difficult to get from them just exactly what they mean. I admit there is such a problem.

Senator **Cranston**. It is difficult to know the numbers, but it is not difficult to understand that that is likely to be the case, that people will not apply when they know people are being turned away, because it is a rather hopeless quest and a waste of time.

Dr. **Ditzler**. Senator, the difficulty of the question relates to the fact that we have 28 million veterans and, as best as I can understand, over the last 10 years, no more than 3 million to perhaps 4 million separately identifiable Social Security numbered veterans receive VA care, so that there is "a suppressed demand that has always existed," and the relationship at any one time of the year is difficult to predict.

Senator **Cranston**. Well, let's go on.

This budget, if adopted, would greatly increase the population of sick and disabled veterans unable to receive needed care. Where many of those are denied care from the VA, there is no real other alternative available. Little or no excess capacity exists in many places to care for those without sufficient resources to pay. They will be the ones turned away by the VA if this budget is adopted.

Let's not lose sight of the fact that we are talking about the very real health care needs of very real individuals, all of whom served our Nation in its Armed Forces, and we are not engaged simply in a budget exercise.

Beyond the concerns I have just expressed for individual veterans and the future of the VA health-care system itself, the proposal in the budget to reduce funding for the medical care account by treating fewer so-called low-priority veterans is also wrong, because I do not see how it is workable.

One major impediment to this proposal is the fact that the phrase "low-priority veterans" is nowhere defined in the budget documents; nor is that phrase used in current law or regulations.

During the House committee's hearing on this budget earlier this month, there was some confusion among the VA witnesses about the extent to which priorities for care are set out in the law.

The only such priorities in current law are in section 612(i) of title 38, and that priority listing is applicable only to outpatient care.

It is also not a comprehensive list since it sets forth priorities only for five categories of veterans and is silent as to priorities among most non-service-connected veterans, the group which would first feel the impact of any reductions in the availability of VA care.

With specific reference now to this issue of which veterans would be denied care under this budget, then, I have the following questions to put to the panel:

How does the VA define "low-priority veterans" for the purpose of denying care as proposed in this budget?

Dr. Ditzler. Senator Cranston, let me apologize to the committee for what I think is an inappropriate term. I do not agree that there is such a thing as a "low-priority veteran."

I think it is a hyphenation of ideas; it is an abomination, and I would say that the whole term is a low-priority choice of words.

Senator Cranston. Good—that is a good description, and I appreciate your apology.

Dr. Ditzler. What it really comes from is, in part, the reference you read on the priorities of certain veterans.

The term itself was used in the original OMB passback relating to low-priority workloads.

So I would like to dispense with calling it that, because what it really means to say is that, if there were a means test, as proposed in the budget, there would be those who would, by law, or at least by new definition of "priority" have unqualified eligibilities as opposed to those who would have to meet a means test, and may or may not qualify.

Senator Cranston. Well, could I seek a more precise answer by posing some hypothetical situations?

If this budget was accepted and no changes in the law were made, what guidance would you propose to give to field facilities for choosing among veterans seeking care?

For example, as between two non-service-connected veterans, one age 58 who is apparently unable to defray the cost of the care needed; and one age 66 who apparently has assets sufficient to pay for the care needed, what would you do in that case?

Dr. Ditzler. I think our guidance to the field would stress that the sickest individual would be cared for if there was an absolute choice required.

Senator Cranston. How would you differentiate between two veterans who satisfy your means test?

Dr. Ditzler. Between two veterans who——

Senator Cranston. Both of whom satisfy your——

Dr. Ditzler [continuing]. Who satisfy a means test?

Senator Cranston. Yes.

Dr. Ditzler. I think medical priority would be the first determination. I believe that we have the capacity, irrespective of priorities to provide care in emergency medical situations.

Senator Cranston. What if both are equally needy?

Dr. Ditzler. We make tough decisions like that every day. I think the individual who requires inpatient care would get the prioritization, because clearly the one who can only be handled on an inpatient basis has a priority for care. I believe that medically it can be substantiated.

Senator Cranston. What guidance would you give for choosing between two non-service-connected veterans, both with limited income, but one of whom is covered by health insurance that would cover the cost of the needed care?

Dr. Ditzler. This presumes no change in law?

Senator Cranston. Either way.

Dr. Ditzler. Well, if there were a change in law, we would obviously have the capability of recovering costs from insurers.

However, again, I think that the decision would have to be made medically.

Senator Cranston. So, in other words, you might take the one that has insurance because——

Dr. Ditzler. I think the temptation would be there, but I still believe that the driving force should be a medical determination.

Chairman Murkowski. Senator, go ahead, you are a little over your 10 minutes, but——

Senator Cranston. OK, I will stop at that point.

Chairman Murkowski. I'll have a second round of questions, if you would be so inclined.

Senator Cranston. Yes; I guess Jay Rockefeller might have some questions too.

Chairman Murkowski. Excuse me.

Senator Rockefeller.

Senator Rockefeller. Thank you, Mr. Chairman.

You indicated, Dr. Ditzler, that an across-the-board cut in health care will be made with respect to medical centers. Now, we have the Huntington, WV, VA Center which, as one of your own studies show, has a staff shortage of almost 24 percent, as compared to an overall staff shortage in VA health care facilities of a little over 9 percent.

When you are making your cuts—given that a hospital has almost a 24-percent shortage, a very severe difference than the 9 percent one—will the across-the-board approach be taken in spite of particularly severe deficiencies in one center as opposed to another?

Or is there room for adjustment within this formula to compensate for deficiencies, clear deficiencies?

Dr. DITZLER. We are now well into a resource allocation methodology by which the hospitals that are most efficient are the ones that get the most resources. Those which are least efficient tend to get less resources, so that there is a natural drive for efficiency that exists in our existing funding mechanisms.

Within this resource allocation system there is some flexibility to make adjustments for a mission change within a group of geographically related hospitals. A shift of resources so that one facility becomes more of a tertiary functioning center, rather than having everyone wanting to be a major tertiary center could be considered. Mission change is probably the thing that is going to drive it most.

Senator ROCKEFELLER. Well, the definition then of efficiency becomes very important. I mean, efficiency could be defined in terms of size of population in a certain regional area; efficiency could be related to the literal efficiency, excellence or nonexcellence of the staff in a particular place.

What does "efficiency" mean? How do you define that?

Dr. DITZLER. We are defining "efficiency" by——

Senator ROCKEFELLER. Are you saying "deficiency" or "efficiency"?

Dr. DITZLER. Efficiency. We are defining efficiency as productivity by measuring each hospital against its peers in terms of the methods by which they take care of patients.

In part, it is related to the DRG phenomena that Medicaid and Medicare use. In fact, it is largely based on that method, so that if hospital A always takes 10 days to treat a patient who should have been cared for in 5 days, they are not nearly as efficient as the hospital that does it in 5 days, or 4 days of admission. Our resource allocation models force facilities to look at the reasons why they are not efficient.

Now, if the reasons they are not efficient are that they do not have enough resources, that is clearly a reason that we would have to correct.

Senator ROCKEFELLER. So that within that definition of efficiency, a deficiency of personnel which leads to inefficiency of services can be adjusted with.

Dr. DITZLER. That can and is being adjusted.

In fact, I believe, with respect to Huntington, we have just recently added some more individuals there.

Senator ROCKEFELLER. Good. OK I appreciate that.

With respect to the beneficiary travel matter, I understand what you are trying to do there. But if you take out the criteria of both need and physical ability to get to medical help, affecting a veteran who literally does not have the financial means or has a physical disability making it impossible to get the care, how is he or she going to get there?

Dr. DITZLER. We have done several studies over the years trying to define the importance of beneficiary travel. It would appear that in 1985 at least $40 million of a total of $98 million was spent for the service-connected veteran who is entitled to those dollars to get to the facility.

This year, in the financing for the 1987 budget, we had the option of applying no dollars to beneficiary travel, or applying those dollars that we felt were critical to get patients who were seriously ill to hospitals. We decided to include a $10 million figure in the budget for emergency types of travel to hospitals.

Senator **ROCKEFELLER**. Is the emergency defined as an "episode" or does it refer to a veteran's condition, either financial or physical?

Dr. **DITZLER**. Primarily episodic due to medical need.

Senator **ROCKEFELLER**. Yes.

Dr. **DITZLER**. This also applies in the rural areas where there is no other way to get to a hospital other than air-evacuated by an air helicopter or air ambulance.

Senator **ROCKEFELLER**. But that would, in fact, be provided because of a health episode?

Dr. **DITZLER**. It would be a health episode.

Senator **ROCKEFELLER**. So that those who are not having an "episode" but who need some sort of treatment, and who do not have either the means or the physical ability except with assistance to get to a VA health facility, now are going to have to, under this budget, fend for themselves?

Dr. **DITZLER**. That is correct.

Senator **ROCKEFELLER**. One more question, Mr. Chairman, on the Emergency Veterans' Job Training Program, that is not a question of a cut, it just simply is not there in the administration's budget at all. I understand the Veterans' Administration is taking the view that since the number of employed veterans has increased, Mr. Alvarez, that this program really is not necessary.

There is another school of thought, I guess, that would say that because of veterans' preference, and because of programs like EVJTP veterans' employment has increased, and that if these programs were taken away, that a step backward would be taken.

Does the removal of, or the not funding of, this particular job training program say that it is not a priority for the Veterans' Administration? It is just not a priority?

Mr. **ALVAREZ**. Well, Senator, the Emergency Jobs Training Act was one that was jointly administered by the VA and the Department of Labor. Initially it was implemented as a program to serve as a catalyst to reduce unemployment with the Vietnam veteran and Korean War veteran eras.

Over that period of time, we had quite a bit of success with this program, more success in some parts of the country than in others, for various reasons.

One of the things we have looked at is that the amount of money that was provided 2 years ago for this program, did not all need to be obligated. There is still money available, which shows that the program has started to decrease in terms of utility. The number of people signing up for the program has decreased for many reasons. We felt that it did not merit resubmission.

Senator **ROCKEFELLER**. With that in mind, might I ask you, Mr. Alvarez, if you could supply this Senator and this committee with a report on the money that is still available and the trends with respect to the use of that program over the last 2 or 3 years?

Mr. **Alvarez**. I would be pleased to, Senator, but you should know that currently we have $17.6 million still available. We can supply you the trends that you requested for the record.

Senator **Rockefeller**. $17 million as opposed to—what was it last year? $65 million.

Mr. **Hoffman**. A total of $65.9 million was carried into 1985. During the year, $10.5 million was transferred from the readjustment benefits appropriation. A total of $76.4 million then was available for 1985.

Senator **Rockefeller**. Yes, well, if I could get the answer to my questions, on trends, that would be very helpful to me.

Mr. **Alvarez**. Yes, sir.

Senator **Rockefeller**. Thank you very much.

[Subsequently, the Veterans' Administration furnished the following information:]

VETERANS' JOB TRAINING PROGRAM
UTILIZATION OF FUNDS
(dollars in thousands)

FY 1984

	Veterans Entering Training	Obligations	Funds Remaining	
October	...	...	...	
November	...	...	...	
December	...	...	$130,000	1_/
January	574	$2,606	$127,394	
February	841	$3,981	$123,412	
March	1,468	$6,796	$116,617	
April	1,836	$7,667	$108,950	
May	2,292	$8,804	$100,146	
June	1,874	$7,006	$93,140	
July	1,515	$6,749	$86,391	
August	3,317	$14,568	$71,823	
September	1,978	$5,943	$65,880	

FY 1985

	Veterans Entering Training	Obligations	Funds Remaining	
October	2,531	$7,325	$58,555	
November	1,603	$8,091	$50,464	
December	1,956	$5,985	$54,979	2_/
January	1,743	$5,801	$49,178	
February	1,892	$7,347	$41,831	
March	2,134	$6,925	$34,906	
April	2,613	$8,338	$26,568	
May	1,503	$5,089	$21,479	
June	1,910	$804	$20,675	
July	1,214	$1,855	$18,820	
August	961	$332	$18,489	
September	844	$926	$17,563	

FY 1986

	Veterans Entering Training	Obligations	Funds Remaining
October	421	$118	$17,444
November	341	$410	$17,034
December	332	$80	$16,954
January	207	$236	$16,718

1_/ Net of $20 million transfer to the Readjustment Benefits Appropriation.

2_/ Unobligated balance of $10.5 million was transferred back to Jobs from the Readjustment Benefits Appropriation.

Yes, Mr. Chairman, I consider this needless to say a very disappointing budget as I am sure you do. We understand that we are under fiscal constraints here, but I think it is the authority of the committee to decide what is fair and do what we feel we need to do.

Senator CRANSTON. Absolutely, I look forward to working with you and other members of the committee to that end. We do have to be restrained in spending obviously to cope with the deficit that is injuring the entire country, but we have got to be fair and we have got to take account of certain commitments that we have. We will work together to that end.

Dr. Ditzler, I would like to make sure we pull back from the brink of the abyss that my last question to you may have been leading you into. You said that if third-party reimbursement legislation was enacted, there would be a temptation to treat the veteran with insurance ahead of the one without insurance.

Do you agree that that would be a bad temptation that the VA should not yield to?

Dr. DITZLER. Yes, it would be a temptation which is why I feel a medical determination should always determine who receives treatment.

Senator CRANSTON. Would you agree then to issue a reg prohibiting the consideration of health insurance coverage in making eligibility for treatment decisions?

Dr. DITZLER. It is sine qua non to my way of thinking, medical determination comes ahead of financial concerns.

Senator CRANSTON. Well, would it not be a good idea to have a regulation out to that effect since some people may be tempted to do what you suggest would be a logical temptation?

Dr. DITZLER. I will be happy to do so, sir.

Senator CRANSTON. I would appreciate that. In your view, Dr. Ditzler, what health care alternatives would there be for the low-income veteran to whom you propose to deny VA care? Would not many of them just go without care in places like Florida and Arizona for example?

Dr. DITZLER. In many cases the veteran who truly may need medical care is able to be placed in the private sector. I find the increased production, if you will, of doctors and the increased competition in the private sector, are making opportunities available that we did not have 3 years or even a year ago.

Senator CRANSTON. Well, would they always be getting that outside care if the VA did not have room for them?

Dr. DITZLER. My understanding is that most of those who really need care, do get it.

Senator CRANSTON. Generally now, and in more detail for the record, would you please describe how the VA would propose to go about allocating the proposed cutbacks in personnel, in in-patients treated and out-patient visits? Specifically, would you use the resource allocation model?

Dr. DITZLER. We will be using the resource allocation model as adjusted by our seven regional directors and our director of operations.

Senator CRANSTON. Would you give us details for the record on that?

Dr. DITZLER. As we get our target budget we will have that data. It will not be immediately available, but it will be shortly.

[Not received at time of publication.]

Senator CRANSTON. All right. If your fiscal 1987 budget request was enacted, would you anticipate that it might be necessary to go further into the population of veterans eligible for VA care, for example, to restrict access to VA care for some service connected veterans for treatment of their non-service connected conditions?

Dr. DITZLER. As I understand our legislative proposal for a means test, we are making exemptions for all service-connectioned veterans.

Senator CRANSTON. Yes, I was not talking about a means test. I was talking about just restrictions on the amount of care that can be given, given the budget problems.

Dr. DITZLER. As currently authorized by law and regulation, it would be restricted based on the space and resources availability. Obviously the service-connected veteran who is being treated for a service-connected condition would have first priority, but I do not forsee there would be a problem with any service connected veteran based on the numerical population of that group.

Senator CRANSTON. Might you be in the position of denying care to a service-connected veteran because he was not a needy veteran?

Dr. DITZLER. I do not believe so.

Senator CRANSTON. Not medically needy?

Dr. DITZLER. The total number of service connected veterans is low enough that I see no problem in providing needed care for all service connected.

Senator CRANSTON. Under the budgets for medical care projected in the President's budget for the out years, would not the restrictions on care for service connected veterans be necessary in future years at least in some high demand areas of the country?

Dr. DITZLER. We would hope to be able to meet the demand by changing our availability in those areas.

Senator CRANSTON. How would you do that in 1991 if you have 90,000 less personnel?

Dr. DITZLER. How many less persons, sir?

Senator CRANSTON. 90,000.

Dr. DITZLER. I am not familiar with the supposition that we are going to have 90,000 less persons.

Senator CRANSTON. I think that is a supposition you can draw from what is proposed. Except that suppose it is 90,000, would that not mean that there would be veterans who are service connected probably unable to be cared for?

Dr. DITZLER. I would have to reason with you that if the hypothetical 90,000 personnel reduction is correct that we would have many problems.

[Subsequently, the following letter was submitted for the record:]

FRANK H. MURKOWSKI, ALASKA, CHAIRMAN

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STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

February 20, 1986

Dr. John W. Ditzler
Chief Medical Director
Veterans' Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear John,

During this morning's hearing on the VA budget, I posed to you a question referring to a 90,000 FTEE reduction in employment levels under the medical care account, based on the 5-year projection on page 27-6 of the VA's budget documents. That 90,000 figure represents the cumulative total of the number of FTEE's that, based on those projections, the VA would lose each year -- as compared to the FY 1986 appropriated level -- over the 5-year period FY 1987 through FY 1991.

The figure that should have been used in the question was 22,000 FTEE -- the approximate difference between the FY 1986 appropriated level, 193,941 FTEE, and the FY 1991 VA-projected level, 171,756. Thus, the question should have addressed the actions needed to reduce patient care workload in light of a 22,000 FTEE reduction in FY 1991.

I sincerely regret the confusion that arose out of the manner in which the question was framed and any embarrassment it may have caused you and your colleagues.

With warm personal regards,

Cordially,

Alan

Alan Cranston
Ranking Minority Member

cc: Honorable Frank H. Murkowski
Honorable Everett Alvarez

Senator CRANSTON. All right. The report of the VA's 1985 survey of demands for VA medical care noted that considerable variation in demand existed among VA regions. Would you provide directly to me and to the committee for inclusion in the record of this hearing full information on the demand in the various DM&S medical regions?

Dr. DITZLER. You are referring to the demand as determined by that 1985 survey?

Senator CRANSTON. Yes.

Dr. DITZLER. Thank you, I will supply that.

Senator CRANSTON. I ask unanimous consent that the 1985 survey of demand for VA medical care together with the supplemental information that I just requested be printed in the hearing record at this point.

Chairman MURKOWSKI. Without objection that will be done.

[Subsequently, the Veterans' Administration furnished the following information:]

The information Senator Cranston requested is provided for the record. In considering this information, we would hope the Committee would keep in mind our previous answer to the Chairman's pre-hearing questions concerning the survey of demand (question 7). To reiterate, the results of that study are not judged conclusive that there is a significantly underserved veteran population which has been denied access to VA care. The survey itself is fraught with definitional and interpretive problems, and it did not capture any information whatsoever on any "suppressed demand"—meaning veterans who do not appear for VA care at all. This was a one-week, one-dimensional "snapshot" data collection, and any conclusions reached thereon should be structured accordingly.

Attachment.

1985 Demand for VA Medical Care Study
Percentage of Patients Accepted for Care

	Total Valid Applicants VA Care as a Percent of Total Valid Applicants Requiring Care.	Total Valid Telephone Requests for VA Inpatient Care Accepted as a Percent of Total Valid phone Requests for Inpatient Care, requiring Such Care.	Total Valid Outpatients Requiring Continued Care that Receive Continued Care as a Percent of Total Valid Outpatients that Require Continued Care.
SYSTEM WIDE	92.39	88.62	97.61
REGION 1	92.74	84.66	98.42
District 1	95.27	83.78	99.12
District 2	92.00	84.62	97.79
District 3	91.94	86.15	98.14
REGION 2	90.77	87.50	97.54
District 4	92.58	81.82	98.60
District 5	93.64	84.13	97.67
District 6	83.51	100.00	98.46
District 7	90.61	89.47	97.03
District 8	93.32	95.59	94.48
REGION 3	85.69	89.64	96.38
District 9	76.05	94.00	93.08
District 10	94.11	90.00	98.08
District 11	95.11	95.83	97.58
District 12	82.76	80.46	95.99

	Total Valid Applicants VA Care as a Percent of Total Valid Applicants Requiring Care.	Total Valid Telephone Requests for VA Inpatient Care Accepted as a Percent of Total Valid phone Requests for Inpatient Care, requiring Such Care.	Total Valid Outpatients Requiring Continued Care that Receive Continued Care as a Percent of Total Valid Outpatients that Require Continued Care.
REGION 4	96.42	92.98	98.37
District 13	95.95	91.21	98.49
District 14	96.54	72.50	99.21
District 15	97.74	100.00	98.24
District 16	96.28	95.16	97.17
District 17	96.86	97.01	98.70
REGION 5	94.85	87.50	97.08
District 18	93.42	86.54	96.79
District 21	95.44	96.47	96.69
District 22	95.38	96.23	97.47
District 23	94.83	65.75	97.42
REGION 6	92.90	79.92	98.21
District 25	92.87	82.56	98.71
District 26	92.08	70.89	97.58
District 27	94.10	84.85	97.78
REGION 7	95.09	94.77	96.65
District 19	95.20	95.00	98.37
District 20	94.82	89.53	90.02
District 24	95.25	98.75	92.04

FEB 24 1986

REPORT OF THE 1985 SURVEY OF DEMAND FOR VA MEDICAL CARE

The HSR&D Service conducted the second annual survey of demand for medical care at all VA facilities (excluding Manila) from April 21 to May 3, 1985. The survey measured the following four indicators of demand in each facility: (1) applications in admitting; (2) telephone requests for transfer; (3) waiting time to next clinic appointment for a new patient; and (4) discharges from outpatient clinics. The survey did not attempt to assess comprehensively the VA's ability to provide all types of care, such as long term care. Further the survey did not attempt to measure suppressed demand for VA medical care. The survey asked facilities to report data compiled from existing MAS records. Therefore, information on the ability of veterans to pay for care could not be collected. Subsequently, the HSR&D Service reviewed a sample of randomly selected patients between June 10 and July 14, at 28 facilities to gather data on the reasons VA facilities could not provide care. Survey methods are described in the technical appendix.

Combining data from all surveys indicates that the VA was unable to provide needed medical care to 8,693 veterans during the survey week. The survey indicated that the VA accepted 92.3% of veterans needing further care and 89.0% of telephone requests for transfer, and continued in clinics or admitted 97.6% of outpatients requiring further care. In terms of veterans requiring further care that the VA was unable to provide, the survey found:

- 7.6% of the 47,712 valid applicants requiring further care (3,642 veterans) could not be given it (see Table 1). A review of social security numbers of persons not accepted for VA care indicated that only 4.8% appeared more than once. Almost all (95%) of these veterans needed outpatient care that could not be provided because of a resource constraint or a facility policy not to accept non-service-connected patients (see Table 2).

- 11% of the 2,566 valid telephone requests for transfer from non-VA to VA care (281 veterans) could not be accepted. Almost all (90%) of transfers not accepted requested in-patient care (see Table 3).

- The average waiting time in 4,195 clinics for a clinic appointment for a new patient was 28.8 days; 19% of all clinics had a waiting time of greater than 45 days; 5% were not accepting new appointments (see Table 4).

- 2.4% of 199,739 outpatients requiring further medical care (4,770 veterans) were discharged (see Table 5). In most cases (76%) discharge was the result of no resource or a facility policy of discharging non-service-connected patients (see Table 6).

- Considerable variation in demand existed among VA regions. For example, 14.3% of applicants in Region 3 were denied needed further care, compared to 3.6% of applicants in Region 4.

Table 1

APPLICATIONS IN ADMITTING

(Week of April 21, 1985)

	Number	Percent	
Total applicants in survey week (unscheduled walk-ins, and requests by mail)	62,944	--	
Valid applicants requiring further care (excluding non-veterans, those not entitled to dental or prosthetic care, and veterans whose evaluation was incomplete on the day of applications, who refused care or who required no further care).	47,712	100.0	
-admitted or scheduled for admission to facility	15,049	[31.5]	(92.3)
-admitted to outpatient care or already in VA system	28,440	[59.6]	
-referred to another VA facility	581	[1.2]	
-needing further care but VA unable to provide it	3,642	7.6	
--referred to the community for care, not at VA expense	1,840	3.9	
--chronic stable condition	1,658	3.5	
--placed on waiting list (which is no guarantee of future care)	144	0.3	

Table 2

TYPES OF CARE DENIED TO APPLICANTS IN ADMITTING AND REASON

The following information is based on 1,015 randomly selected cases in admitting who were not accepted for care at 28 facilities. Since these data are not based on a complete census they should be interpreted with caution.

Reason according to survey reviewer	Inpt.	Outpt.	Total
Service not provided at facility	0.5%	2.0%	2.5%
Resource constraint (a)	3.6%	55.8%	59.4%
Facility policy not to accept non-service-connected patients	0.5%	22.8%	23.4%
Patient preferred local medical doctor	0.0%	2.5%	2.5%
Patient leaving area, refused continued care	0.5%	2.5%	3.0%
Other	0.0%	9.6%	9.6%
TOTAL	5.1%	94.9%	100.0%

(a) For inpatient care, no bed of the type needed available at the time of the request; for outpatient care, waiting time to next available appointment in appropriate clinic too long.

Table 3

TELEPHONE REQUEST FOR TRANSFER

(Week of April 21, 1985)

	Inpt.	Outpt.	Total	Percent
Telephone requests for transfer	2,937	488	3,425	--
Valid telephone requests (excluding non-veterans, cases with insufficient information, no service at facility, patient unstable).	2,368	434	2,802	--
Valid requests requiring further care	2,132	434	2,566	100.0
-accepted for transfer (within 48 hours in case of inpatient care)	1,883	402	2,285	89.0
-not accepted for transfer	249	32	281	11.0
--insufficient resources (beds not available or long clinic waiting times)	116	13	129	5.0
--veteran had chronic stable condition	--	13	13	0.5
--placed on waiting list (which unlike scheduled admission is no guarantee of future care)	133	6	139	5.4

Table 4

OUTPATIENT CLINIC WAITING TIME TO NEXT APPOINTMENT FOR A NEW PATIENT

(During the Week of April 28, 1985)

	Number	Percent
Total clinics reporting (a)	4,195	100.0
Clinics within the system not accepting new appointments	193	4.6
Clinics within the system with waiting time to next clinic appointment for a new patient greater than or equal to 45 days (b)	812	19.4
The average, system-wide weighted waiting time to next clinic appointment for a new patient (in days).		
-all patients (c)	28.8	--
-service-connected patients	26.6	--
-non-service-connected patients	30.2	--

(a) The survey covered 36 different types of clinics, accounting for almost all outpatient care at all facilities.

(b) The time set by the Chief Medical Director in January 1984 as a reasonable waiting limit.

(c) The average waiting time is calculated based on weighting each clinic's time by the proportion of patients seen and the proportion of a facility's patients that are service-connected and setting an arbitrary waiting time of 90 days for clinics indicating they were not accepting appointments for new patients.

Table 5

DISCHARGES FROM OUTPATIENT CLINICS

(Week of April 28, 1985)

	Number	Percent	
Number of outpatients seen (scheduled patients plus walk-ins minus no shows) (a)	208,563		
Number in need of further care (excluding veterans, for who no further treatment was needed).	199,739	100.0	
-admitted or scheduled for admission to VA	5,418	[2.7]	
-admitted to another VA or non-VA at VA expense	420	[0.2]	-(97.6)
-given a return appointment, followed in another clinic	189,131	[94.7]	
-discharged	4,770	2.4	
-continued care indicated but VA unable to provide it	1,610	0.8	
-patient had chronic stable condition	3,160	1.6	

(a) At 36 types of clinics at all facilities that met during the survey week. This count excludes patients seen in admitting, employee health and collateral visits, and compensation and pension, and agent orange exams.

Table 6

REASON VETERANS NEEDING FURTHER CARE WERE DISCHARGED FROM OUTPATIENT CLINICS

The following information is based on 812 randomly selected cases not given a return appointment to the clinic at 28 facilities. Since these data are not based on a complete census they should be interpreted with caution.

Reason, according to survey reviewer	Percent
No resource (a)	43.7
Facility policy to discharge non-service-connected patients	30.2
Patient preferred local medical doctor	13.4
Patient leaving area, refused continued care	3.4
Other	9.2
Total	100.0

(a) Insufficient clinic space/staff to continue the patient in treatment or the need to discharge the patient to make room for new veteran patient with higher priority.

TECHNICAL APPENDIX

This technical appendix summarizes 1985 survey methods. The 1985 survey instruments were revised versions of those used in 1984. Revisions were based on the review of 1984 survey data, a review of draft 1985 forms and instructions by VACO personnel and survey reviewers, and pretests. Survey forms and instructions were mailed to all 171 VA medical centers, 7 freestanding outpatient facilities (all except Manila), and 58 satellite outpatient facilities. Facility directors were asked to appoint both a survey and a physician coordinator. We asked coordinators to read forms and instructions and call in questions. The CMD held an all-facilities conference call on April 12, 1985. During this call, we answered all questions call in previously and arising during the call. The survey was conducted over a two-week period as follows (and described below):

- April 21 to 28, 1985 - Form 1, Applications in Admitting; and Form 2, Telephone Requests for Transfer;
- April 29 to May 3, 1985 - Form 3, Outpatient clinic waiting time for next appointment for a new patient; and Form 4, Discharges from outpatient clinics.

All the forms were returned to the HSR&D Service, where they were checked for accuracy and completeness by a medical reviewer and a member of the research staff. Unusual responses or unusual patterns of responses were verified with the facility via telephone. In addition, data checks for unusual data were performed by the computer. All data were double keypunched for accuracy.

The survey measured four separate indicators of demand for care in each facility, as follows.

1. Applications in Admitting. The admitting area of a VA facility is the entry point for veterans seeking care. Personnel in the admitting area not only evaluate the medical needs of the veteran, but determine legal eligibility and priority for VA care. Veterans may apply for care in person or via mail application. We surveyed all facilities for an entire week starting on April 21, 1985. The survey asked that the charts of patients neither admitted, scheduled for admission, nor given a clinic outpatient appointment (i.e., patients not accepted for care) be reviewed by a physician to determine whether the patient required further care and by a Medical Administration Service (MAS) representative to determine eligibility. This information was then recorded on the data forms. This survey may have slightly underestimated the number of eligible veterans denied care.

2. Telephone Requests for Transfer. Non-VA providers (e.g., hospitals, nursing homes, private physicians) may request the transfer of veterans under their care to the VA. This survey was conducted for the entire week of April 21, 1985. Facilities were instructed to refer all telephone requests for transfer to a centralized point. They were then recorded on either an inpatient or outpatient form, indicating the disposition of the request. We gave facilities 48 hours to determine these dispositions. (Since no formal system-wide mechanism exists to capture these requests, this survey probably under-reports the number of telephone requests for transfer. However, as a result of the FY 1984 survey, some facilities have established systems to record telephone requests for transfer more reliably.)

3. Waiting Time to Next Appointment for a New Patient. Thirty-six types of outpatient clinics (e.g., general medicine, podiatry) with the heaviest patient loads were surveyed at each facility during the 5-day work week of April 29, 1985. Facilities were asked to consult their logs on any given day during the week to determine the next available clinic appointment for patients new to the clinic. Because some facilities give priority to veterans with service-connected disabilities, clinics were asked to report waiting times separately for service-connected and non-service-connected veterans.

4. Discharges from Outpatient Clinics. This survey was conducted at all VA facilities during the 5-day work week April 29, 1985, in the same 36 clinics surveyed for clinic waiting time. The survey called for an MAS clerk to record discharges and for a clinic physician to determine the reason the veteran was not given a return appointment to that clinic.

One month after completion of the full survey, a stratified random sample of 28 facilities were selected for a follow-up survey review to assess data reliability and to collect supplemental data on type of reason for care denied. Within each sampled facility, random samples were drawn of patients rejected from admitting and of patients discharged from clinics. Between June 10 and July 14, each facility was visited by a VA physician who reviewed the charts of the selected patients. These physicians independently judged (without reference to the facility's original survey report) the status of those patients not accepted for care in admitting or discharged from the outpatient clinics. These physicians also determined the type of medical care denied and the reason care was denied. Data quality control procedures identical to those employed for the survey were used for review data.

Senator **Cranston**. With further reference to the VA survey of demand for care, I note that in the description of the health services research program it is mentioned that plans are being made for a 1986 survey. When will that survey be carried out and when will the results be available?

Dr. **Ditzler**. The survey that was conducted the last week of January, sir, is currently being tabulated. I suspect it will be the same number of months as last year which will bring it to late summer probably.

Senator **Cranston**. Dr. Ditzler, as you know I have urged that the survey be done annually on a regular basis. Why have you resisted that idea?

Dr. **Ditzler**. I have not, sir. It has been done as of 2 weeks ago.

Senator **Cranston**. Is it going to be done annually from now on?

Dr. **Ditzler**. Some part of the survey should be done. Whether it is that form, I have some doubt because I think technically it left us with a lot of unanswered questions. So we are currently trying to resolve the issue of how to get a better survey.

Senator **Cranston**. Well, obviously the questions ought to be sharpened in the survey.

With reference to the 1985 survey, how many of the veterans who are turned away both needed care and were eligible for care from the VA?

Dr. **Ditzler**. My understanding is that they were all eligible for care. In fact the process of determining that they were not going to be cared for in part required that they first be medically examined to determine whether they could be offered alternatives to care.

Senator **Cranston**. Would you look at that again and then supply an answer for the record because I gather that some needed care and were eligible for care, but were turned away. Would you take a look as to whether that happened and how many?

Dr. **Ditzler**. Yes.

[Not received at time of publication.]

Senator **Cranston**. Some were not eligible. If your budget request for the medical care account was enacted, please explain specifically what steps you would take on or before October 1 to implement the reduced staffing level?

Dr. **Ditzler**. Senator, that creates a problem for us because we are in agreement, I believe, with both House and Senate, that we would maintain 192,635 FTEE for medical care this year. So there would be a difficulty in achieving the approximately 185,000 FTEE on October 1, 1986.

So there would be an attrition and a management problem occurring in the 1987 budget to achieve this. That is quite correct, we do agree.

Senator **Cranston**. 194,000 now?

Dr. **Ditzler**. No, we are at 193,522 approximately 900 above our end of year target. Since we will experience some reduction before September 30, it would be impossible to be at the 185,000 employment level on October 1 without RIF's or firings and we do not intend to do that.

Senator **Cranston**. Would you please submit for the record full details as soon as they are available on staff reductions that would be needed in VA health care facilities if your budget request is enacted.

[Not received at time of publication.]

Senator CRANSTON. Based on the projections set forth on page 27-2 of your budget documents in what year would you start closing entire facilities such as hospitals, clinics and nursing homes in order to make optimum use of available resources?

Dr. DITZLER. Senator, we have no plans to close any facility. We do have plans, however, to consolidate the activities of several of our hospitals, and we plan further to extend the development of nursing home beds in some of those hospitals rather than providing acute care.

Senator CRANSTON. You have no plans, including in the four out years?

Dr. DITZLER. We have no plans as of this time for any closure.

Senator CRANSTON. Do you not think you might have to, given the budget constraints?

Dr. DITZLER. Under your supposition of 90,000 fewer personnel, yes.

Senator CRANSTON. Was your original request to OMB for fiscal 1987 for the medical care account $10.041 billion as the PVA testimony asserts?

Dr. DITZLER. That is approximately correct. I have a figure here I can give you more accurately, $10,041,582,000.

Senator CRANSTON. How many episodes of in-patient hospital care and nursing home care, and out-patient medical and dental visits did you estimate in that request that you would have provided with that level of funding?

Dr. DITZLER. May I supply that for the record, sir?

[Subsequently, the Veterans' Administration furnished the following information:]

The workload estimates included in the 1987 OMB request are detailed in the chart below:

1987 workload request

Activity	*Total*
VA hospital patients treated	1,316,931
VA Nursing home patients treated	20,599
Outpatient care:	
Medical staff visits (000)	18,121
Medical fee visits (000)	1,888
Dental fee visits (000)	22
Dental staff exams (000)	190
Dental staff treatments (000)	200

Senator CRANSTON. All right. Did not the funding level that you are requesting for research permit you to maintain your current FTEE level for research programs in fiscal year 1987 and because of that did you not request OMB to permit you to maintain that FTEE level?

Dr. DITZLER. I will have to submit that for the record.

Senator CRANSTON. All right.

Dr. DITZLER. I am not clear on that.

Senator CRANSTON. PVA in its testimony for today's hearing states that, "in OMB documents relating to the VA's 1987 passback . . . mention made of restricting VA health care to nonservice connected veterans to a maximum of 500,000 episodes in fiscal year 1987. The OMB directive to the VA indicated that it would approve funding for 1,243,700 in-patient episodes of veteran care, and limit nonservice-connected veterans to 500,000 episodes."

Is that statement accurate, and if so, what was the VA's response to OMB?

Dr. DITZLER. The statement is accurate. We appealed it and we won the appeal and the right to take care of the patients as we saw fit.

Senator CRANSTON. I would like to go back to the question I asked which you said you would like to submit for the record. I would like to see if there is somebody here from the VA who could answer it now instead of waiting for a written response because I am not sure what that written response would be.

So let me repeat the question, and if there is anybody here from the VA who could answer it. Would not the funding level that you are requesting for research permit you to maintain your current FTEE level for research programs in fiscal 1987 and because of that did you not request OMB to permit you to maintain that FTEE level?

Dr. DITZLER. John.

Dr. GRONVALL. Mr. Cranston, I believe I can answer without referring to specific numbers. In 1986 we had a reduction in the research budget as a result of the Gramm-Rudman sequestration order. That left us in 1986 with a reduced amount of money to support research projects. We chose to restrain and constrain the project budgets for ongoing projects rather than terminate personnel who had already been committed to work on projects in 1986.

In the 1987 budget request, we show an increased budget for research as compared to the reduced 1986 amount. In looking at the most appropriate mix of personnel as well as nonpersonnel costs in the research projects, we felt that the budget in 1987 even though higher in total dollar amount would provide a more balanced research project mix by slightly reducing the amount of personnel supported by that higher level.

That was a judgment expressed or made within the VA itself. The dollar level for the total research budget request in 1987 was fixed by the budget strategy established by the administration.

Senator CRANSTON. Did you ask OMB to permit more FTEEs than you are now asking in the budget request?

Dr. GRONVALL. I believe I am correct that, once the dollar level of the 1987 budget was fixed, we made the judgment about the appropriate personnel level to be supported by that budget.

Senator CRANSTON. I thank you. The chairman has returned, and I have to go to a meeting on another matter. So I will submit some more of these questions for the record, and I would appreciate an effort to get the answers to us so we can be prepared for our budget deadline.

[The questions and responses appear on p. 756.]

Mr. ALVAREZ. Thank you, sir.

Dr. DITZLER. Thank you.

Chairman MURKOWSKI. Did you get 250 of the 300?

Senator CRANSTON. I think almost.

Chairman MURKOWSKI. OK. Thank you, sir.

Senator Cranston talked earlier on the question of the demand for medical care at VA facilities and the attention that it has received based on the "1985 Survey of Veterans' Demand for Medical Care". Some have interpretted that study to say that 30,000 veterans are being turned away from VA hospitals or out-patient clinics each month.

I do not know the accuracy of that, but the same survey indicated that 92.3 percent of the valid veteran applicants were cared for. Is that correct, incorrect or just a guess?

Dr. DITZLER. Mr. Chairman, that is a guess at the moment because there are certain defects in that survey that simply do not tell us by social security number whether we are talking about a veteran who was seen on Monday of last week and on Tuesday of this week was turned down.

Chairman MURKOWSKI. OK.

Getting back to the loan guaranty matter, I submitted some questions earlier for the record regarding the recent auction held in Houston to dispose of foreclosed properties in the VA inventory. I wonder if you could provide the Committee with the bottom line of this auction.

Did the VA realize a larger loss by proceeding with the acquisition of the subject properties at foreclosure, inasmuch as it would appear that the VA held the properties in excess of two years and subsequently sold them through the auction, or would the VA loss have been greater had it paid the guaranty to the lender at foreclosure and then in effect have the lender sell the property?

Mr. VOGEL. Senator, the bottom line at the Houston auction was that we realized about 65 cents on the dollar on the listed prices of the property. The phenomenon of the greater Houston area is that depreciation of properties is going so fast that it is very difficult to keep up with.

Chairman MURKOWSKI. Are you saying depreciation or appreciation?

Mr. VOGEL. Depreciation—we are seeing situations in which a veteran purchases a home for $50,000 in 1981 and the appraised value at the time of the foreclosure sale is $20,000 or $25,000. Whether or not it would have been more expeditious to have paid the claims in these cases, is very difficult to estimate.

We are doing an analysis of all the properties sold to determine the original appraisal, the appraisal at the time of auction and how much the claim would have been if we had paid only the claim.

Chairman MURKOWSKI. My concern, I think you are aware of it, is the fact that the VA held some of these properties for quite a while. In holding them the VA accrued costs and there were all kinds of exposure to vandalism and whatever. Why is it not more practical to consider a change in VA procedure, so as the VA picks up foreclosed property, it would pay off the guaranty to the lender, and let the lender sell the property or have the VA move out and let the local real estate market become involved?

By dumping that much property on a market particularly when you have a depreciation situation would seem to just worsen it. You say you realized 65 cents on the dollar is just that and nothing more.

Mr. Vogel. Those properties that were auctioned were in the inventory for approximately 22 months.

Chairman Murkowski. That is my point.

Mr. Vogel. We are paying taxes, paying maintenance, and repairing them. These were some of our most distressed properties. The properties that move fast are the most desirable ones.

We attempt to sell them by whatever means possible during the time we have them in inventory. At the Houston regional office, we sell approximately 200 properties a month. We acquire about 400 properties a month.

It has been going on that way for a long time. They have about 4,500 properties in custody just in the Houston regional office jurisdiction. Generally they are in greater Houston.

In the national inventory we currently have about 19,000 properties in title. Those we have acquired in the upper Midwest—Cleveland, Detroit, Milwaukee—which had previously been our most difficult area are selling more rapidly than in previous years. So there is an economic up swing.

Chairman Murkowski. Well, roughly what percentage of foreclosed properties are purchased currently by the VA in Houston?

Mr. Vogel. It is in the 55 to 60 percent range, sir.

Chairman Murkowski. Not higher? It is not around 80 or 85 percent?

Mr. Vogel. No, sir.

Mr. O'Toole. Senator, we will provide it more accurately for the record, but it is slightly above the national average, which is running about 84 percent.

[Subsequently, the Veterans' Administration provided the following information:]

Currently in Houston the VA is acquiring approximately 90 percent of the properties that are being foreclosed.

Chairman Murkowski. I am just wondering though, Mr. Vogel, why it would not be more expeditious as you pursue a foreclosure and the VA basically purchases that property, why the VA does not move the properties on a continuous chain rather than hold them for an auction? I know you have got them up for sale in effect, but I am wondering if there is not room for a reexamination of the process since you are in a situation where you are not going to be bailed out by appreciation. You know that for a fact. Virtually all over the country real estate is not appreciating as it once was. Is it not time to reevaluate procedures to see if there is a more expeditious way to cut down on the losses which result in this tremendous inventory?

Mr. Vogel. We are at present, Mr. Chairman, looking at having a significant portion of our property inventory, perhaps as much as 10 percent, managed and sold for us by private sector contractors.

We are looking at that now. We expect to put a description of what work we would like to have done out, as early as next month. The process of awarding the ultimate contract is a rather lengthy one, but we intend to do that. The expectation is that we are going to run a parallel group of properties that we are managing to see which works better.

We know that the cost of the private sector disposal on the face of it appears to be higher, but if they turn those over more quickly than we can, ultimately the program would be better for it.

Chairman MURKOWSKI. Do you think it is worthy of consideration to invite—I am not suggesting you necessarily go out and contract because I think there is enough talent in certain areas—maybe mortgage bankers to come in and look at your operation and make some constructive suggestions to move that inventory in a more expeditious manner?

Mr. VOGEL. Yes, sir, you are quite right. We have had meetings with Home Equity, Lomas & Nettleton and The Associates to describe our process. They are very well acquainted with it. We described it in some amount of detail. It was from these meetings that we decided to go ahead and pursue the notion of contracting out part of the inventory.

I think there are resources available on a consultative basis, and the price is certainly right. I think they are prepared and even willing to do so gratuitously for us. It is a thing we must and should take advantage of.

Chairman MURKOWSKI. I would be interested in knowing what your plan is in that area because it has come up in previous years and it is something that I feel can be improved. I would be interested in knowing what your structure is.

In your budget document there is an acknowledgement that the Veterans' Administration currently acquires about 90 percent of the properties foreclosed, with the exception of mobile homes which are repossessed and resold on the market by the lenders.

Since this I assume is correct because it comes from your budget documents, could you provide this committee with a rationale on why the lenders move the mobile homes and not the houses? If it is good enough for the mobile homes, why is it not good enough for the houses?

Mr. O'TOOLE. Senator, the procedure for foreclosure of the mobile home is that we do not acquire. We pay the claim and that is simply because of the nature of the mobile home business.

Chairman MURKOWSKI. But you have that same option.

Mr. O'TOOLE. We have that option within the limitation established by the law, but the formula which is used to determine whether to acquire or not acquire is now in the law. The law has a provision that we will acquire no fewer than 65 percent of those that go to foreclosure.

[Subsequently, the Veterans' Administration provided the following information:]

Public Law 98-369 established a formula for the acquisition versus non-acquisition of foreclosed property by the VA. The law does not contain any numerical requirements.

Chairman MURKOWSKI. That does not make sense, does it?

Mr. ALVAREZ. That was implemented, sir, I think last year as I recall.

Mr. O'TOOLE. In 1984 as I recall.

Chairman MURKOWSKI. Just a minute. Mr. Principi has a question on that, and I am going to let him enunciate it.

Mr. **Principi**. I do not believe that was proposed as a limitation upon you. That was designed to get you to buy back less property and to be more realistic in computing your costs to determine whether to purchase back the property or pay off the guaranty.

It is terribly misleading to state that that is the formula that must be applied in each and every case, and that you have no leeway at all to pay off the guaranty in more cases.

Mr. **O'Toole**. Well, we have some leeway but we certainly do not have any leeway in following the formula which I think is very clear in the law. The alternative to that law was that we would not acquire any property.

I think if you look at the background, one of the alternatives was not acquire at all and there was some feeling that there should be some provision to allow us to acquire in those instances where we could recover.

There was a determination made that it was less costly to acquire and resell than it was to pay off the claim amount.

Chairman **Murkowski**. On what basis though? Who made that interpretation?

Mr. **O'Toole**. Well, before the law was passed, Senator, we acquired 98 percent of the cases.

Chairman **Murkowski**. The VA currently acquires foreclosed properties in 90 percent of the cases?

Mr. **O'Toole**. No, now we are acquiring in the neighborhood of 84 percent of the cases.

Chairman **Murkowski**. Well, it says here 90 percent, and this is your fiscal year 1987 budget submission.

Mr. **O'Toole**. Well, for budget purposes we estimated 90.

Chairman **Murkowski**. You say 55 percent in Houston?

Mr. **O'Toole**. Approximately.

Chairman **Murkowski**. I am sure you understand my concern here. Why is it better to do it this way as opposed to just paying off the guarantees in the first place?

Mr. **O'Toole**. Because, on those houses that we were able to sell, the average loss was in the $13,000 to $14,000 range.

Chairman **Murkowski**. Yes, but how long are you holding them?

Mr. **O'Toole**. Well, 10 months is the nationwide average. Compare the average loss of $13,000 or $14,000 if we acquire the property, and a maximum of $27,500 if we paid the claim.

Mr. **Alvarez**. Mr. Chairman?

Chairman **Murkowski**. Mr. Alvarez.

Mr. **Alvarez**. This is an issue in an area that we have had quite a bit of concern for, for the last several years. When we got into it, I asked Mr. Vogel to develop a plan. Part of that plan was to bring in options to show us how to best manage this portfolio program against the option of not acquiring at all.

We would like to have an opportunity to go ahead and continue to develop this. Then when that is completed, we would meet with you again and look at the various questions. At this point I do not think we are able to address these issues in any better detail.

Chairman **Murkowski**. All right, Mr. Alvarez, I appreciate that. I think this is a replay of a discussion we had a year or so ago on the same subject. I think you as well as I would like to feel a little more secure that there is not a better way to proceed, and that we need a change in law that would expedite the process and increase efficiency. You know that recommended change should come from the Veterans' Administration, and Congress should proceed with the implementation. Mr. Principi, do you have some questions?

Mr. PRINCIPI. In relation to the auction could you, please provide the committee with the total cost to the VA of acquiring, holding—including all costs for management, taxes, fix-up, interest—and selling each property sold at the recent auction in Houston?

Chairman MURKOWSKI. Well, I do not know whether we want each one, but at least a compilation.

Mr. PRINCIPI. Also, the amount of guaranty that you would have had to pay had you elected to pursue that course for the properties at the Houston auction.

Mr. VOGEL. Yes, we will.

Mr. PRINCIPI. Thank you.

[Subsequently, the Veterans' Administration provided the following information:]

The total cost to VA of acquiring and managing the guaranteed loan properties that were sold in the February 5, 1986 Houston auction is estimated to be $10,309,710. The net proceeds from the auction sale of these properties was $4,639,293. Therefore, the net loss to VA from the acquisition and resale of these particular properties is $5,670,417. For these particular properties, based on what is now known about the prices actually obtained at resale, it would have been $697,437 less expensive to have paid the maximum claims and to not have acquired the properties. However, we believe the decision making process on whether to acquire these properties was sound and based on a reasonable assessment of the real estate market at that time.

At the time of the foreclosure sales the properties had an appraised market value of $11,035,035. Had these properties been able to be sold at that figure, less the customary 5 percent selling expense, the net sales figure would have been $10,483,284 and it would have been $5,510,304 more expensive to have paid the guaranty rather than acquiring and reselling the properties.

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
1	20970	NA	15,500	NA	10,710	3,500
2	26228	NA	35,000	NA	11,475	6,000
3	425985	24,500	26,825	14,700	13,770	5,500
4	517626	32,500	25,000	19,500	13,000	10,500
5	525160	32,700	33,000	19,620	21,100	6,500
6	514467	50,000	27,000	27,500	22,600	7,000
7	574060	29,900	29,900	17,940	16,800	7,750
8	454224	29,800	35,950	17,880	14,500	6,000
9	537747	44,300	44,000	26,580	18,360	8,250
10	543623	35,000	39,500	21,000	14,500	8,250
11	501317	26,000	28,400	14,000	15,300	6,500
12	494876	47,000	39,500	27,500	16,800	12,000
13	24106	NA	43,400	NA	15,300	5,000
14	544471	27,300	29,000	16,380	15,300	3,250
15	453183	46,450	50,000	25,000	18,000	19,500
16	552357	62,300	59,500	27,500	21,800	17,000
17	495580	37,500	39,550	22,500	29,000	9,000
18	525343	36,800	41,450	23,160	10,300	4,000
19	492580	54,900	39,000	25,000	19,100	20,000
20	537951	36,500	40,000	21,900	26,000	6,500
21	477803	33,000	35,600	19,150	22,950	16,750
22	525598	54,450	54,750	27,500	27,500	17,000
23	568533	47,000	39,900	27,500	29,500	15,000
24	538087	42,500	42,250	25,500	32,100	20,000
25	537907	36,500	37,200	21,900	34,800	15,000
26	524829	43,500	52,500	26,100	25,250	16,000
27	502438	34,000	43,000	20,400	15,300	12,750
28	539256	61,950	55,000	27,500	28,700	24,250
29	514705	41,500	36,000	12,800	33,300	26,000
30	501607	39,900	48,000	23,940	24,500	13,500
31	539737	45,500	48,200	26,320	25,250	13,000
32	540232	48,250	57,400	12,200	24,500	10,500
33	433748	35,500	46,700	21,300	27,500	12,000
34	542209	45,000	44,000	26,970	20,700	15,000
35	523047	46,600	46,600	27,500	26,400	26,000
36	549303	50,950	50,950	27,500	24,900	13,500
37	524030	44,950	47,550	26,920	23,700	22,750
38	502708	47,700	48,600	27,500	39,400	25,000
39	543425	50,700	59,850	27,500	25,600	19,750
40	519473	50,000	52,700	27,500	30,600	25,000
41	544873	53,950	62,850	27,500	22,200	26,500
42	25973	NA	63,100	NA	23,000	19,500
43	551567	65,750	58,250	27,500	30,600	28,250
44	26453	NA	57,500	NA	38,250	21,750
45	524793	49,950	55,000	27,500	38,250	32,500
46	536903	42,000	50,000	25,500	29,800	17,000
47	480299	49,250	64,900	25,000	38,250	21,500
48	501638	51,000	66,500	12,750	9,950	25,000
49	538491	53,000	55,000	27,500	29,500	28,500
50	493837	68,600	57,250	24,633	45,500	28,500
51	389439	49,300	60,000	11,575	45,900	17,500
52	26280	NA	70,000	NA	47,400	32,000
53	477805	65,000	71,500	16,000	15,300	15,000
54	516821	62,500	60,000	27,500	48,600	16,000

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
55	433234	45,000	69,700	17,500	51,600	31,000
56	522710	60,500	74,800	27,500	38,250	32,500
57	517330	60,000	83,000	27,500	39,800	40,500
58	405912	48,000	59,950	17,500	55,900	33,000
59	519106	66,900	71,800	16,730	39,000	25,000
60	501629	76,500	82,000	27,500	61,100	49,000
61	449797	66,500	69,000	25,000	48,200	42,500
62	492604	74,500	73,000	25,000	40,500	45,000
63	524506	140,000	142,000	10,000	75,700	87,000
64	498262	75,200	78,000	25,000	42,850	47,000
65	540906	83,950	89,000	27,500	43,200	57,000
66	569378	80,850	71,000	27,500	42,100	41,000
67	522021	64,950	55,000	27,500	59,300	40,000
68	518834	63,000	77,800	27,500	52,000	32,500
69	522126	69,900	74,300	27,500	38,600	49,000
70	522071	70,700	76,500	27,500	39,400	40,000
71	501412	62,950	68,000	27,500	33,650	40,000
72	515987	60,900	69,500	27,500	49,300	35,000
73	472443	57,000	58,700	25,000	39,000	38,000
74	566043	61,950	61,950	18,124	34,100	32,000
75	524583	57,950	65,600	27,500	42,100	28,000
76	583095	56,950	62,300	27,127	34,100	33,000
77	516697	60,000	70,000	15,000	37,500	44,500
78	549289	59,500	60,000	27,500	44,800	28,000
79	413080	48,200	60,000	17,220	35,600	36,000
80	566636	56,500	56,500	27,500	40,163	21,750
81	540649	56,500	56,350	27,500	34,050	25,000
82	553530	62,000	58,000	27,500	32,512	27,500
83	520569	57,950	59,000	27,500	30,600	27,500
84	538693	59,450	61,600	27,500	41,300	37,000
85	574691	58,000	52,000	27,500	37,900	27,500
86	26416	NA	57,200	NA	32,500	15,500
87	540818	47,950	48,300	27,500	37,500	24,000
88	472837	38,000	47,100	22,800	30,600	27,000
89	538793	47,450	55,000	27,500	35,200	16,000
90	545489	51,950	60,500	27,500	27,500	28,000
91	539714	53,450	64,675	16,035	25,600	21,500
92	26850	NA	61,200	NA	27,500	19,000
93	521560	44,950	46,500	26,970	37,100	21,500
94	540248	48,150	49,000	27,500	22,600	22,500
95	433067	36,800	43,900	26,599	24,500	21,000
96	501983	46,500	46,800	27,500	25,250	24,500
97	519225	44,500	51,000	25,770	19,100	20,000
98	492962	39,300	46,900	23,580	27,500	15,250
99	537275	39,500	39,800	23,700	19,500	7,250
100	549802	48,200	43,750	27,500	27,500	21,000
101	542581	48,500	51,500	27,500	32,100	16,000
102	571494	47,700	39,000	27,500	24,500	7,000
103	481699	43,000	39,000	23,970	20,700	12,250
104	493399	48,950	63,400	25,000	29,100	26,750
105	26119	NA	35,000	NA	20,700	5,250
106	543456	33,500	35,300	20,100	20,700	7,000
107	524067	62,500	50,500	27,500	28,700	19,500
108	26472	NA	33,500	NA	19,100	12,000

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
109	524764	35,000	38,500	16,800	25,600	18,500
110	481041	49,950	54,000	25,000	18,000	21,250
111	517565	56,500	49,000	27,500	24,900	17,000
112	26312	NA	35,500	NA	29,100	10,000
113	540920	25,000	33,500	15,000	19,125	6,500
114	545048	32,000	30,900	18,930	11,500	7,000
115	523883	34,900	35,800	20,940	19,100	4,250
116	539956	37,950	40,000	22,770	23,000	11,500
117	545810	29,900	26,600	14,590	7,650	5,500
118	517976	22,500	31,150	13,500	17,200	9,500
119	23987	NA	17,000	NA	4,590	4,750
120	554599	40,000	35,000	16,600	14,200	15,500
121	26103	NA	33,000	NA	16,800	22,000
122	16456	NA	14,300	NA	9,600	5,000
123	501701	47,500	32,500	27,500	16,100	12,500
124	14223	NA	8,000	NA	5,350	4,250
125	459748	31,800	30,000	11,400	1,150	3,000
126	25523	NA	27,000	NA	9,950	9,000
127	497684	36,000	40,000	21,600	6,100	3,000
128	387102	10,500	25,000	6,300	11,500	6,000
129	28137	NA	29,500	NA	25,250	12,000
130	515435	50,000	49,000	27,500	19,900	9,500
131	26177	NA	25,550	NA	13,000	6,500
132	25613	NA	39,500	NA	19,900	7,500
133	24024	NA	20,100	NA	8,000	6,500
134	406191	13,500	24,900	8,100	12,250	8,000
135	25207	NA	32,500	NA	13,000	3,000
136	539698	44,500	45,500	26,670	23,700	15,000
137	25334	NA	32,550	NA	24,900	9,500
138	519514	29,900	39,600	10,000	15,700	11,000
139	536639	43,900	43,400	25,740	15,300	14,000
140	481094	57,500	45,000	25,000	18,700	27,000
141	389148	30,550	15,000	8,576	19,100	7,000
142	546386	36,700	35,500	21,900	21,420	12,500
143	537912	35,500	41,000	21,300	19,100	15,000
144	550607	61,500	56,000	27,500	27,500	23,000
145	522456	35,000	42,500	11,300	32,500	21,000
146	435744	34,500	40,200	20,700	19,100	16,000
147	542570	46,000	51,350	27,500	29,500	17,000
148	492676	38,500	47,000	23,100	18,700	19,000
149	26053	NA	65,000	NA	27,500	35,000
150	542842	46,500	46,500	27,500	21,400	20,000
151	546298	49,250	51,100	22,500	24,900	22,500
152	536667	43,000	43,000	27,500	25,250	17,000
153	540652	45,500	48,500	26,970	25,600	17,000
154	570354	54,000	54,000	27,500	23,700	23,000
155	524861	39,300	46,500	23,580	23,300	19,000
156	544034	60,000	57,000	27,500	25,600	23,000
157	518468	62,500	64,150	27,500	32,900	35,000
158	540269	45,500	46,450	26,970	22,950	17,000
159	519972	51,950	51,950	27,500	34,000	24,000
160	537137	54,800	52,500	27,500	32,500	20,000
161	26502	NA	52,000	NA	29,800	21,000
162	449264	42,100	57,500	25,260	29,800	21,000

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
163	27358	NA	53,250	NA	39,000	18,000
164	554125	54,800	52,400	27,500	22,950	17,500
165	548472	48,500	52,000	23,000	32,100	17,500
166	476784	49,950	60,200	24,189	30,600	33,000
167	544684	50,150	54,500	27,500	28,700	32,000
168	501200	53,850	60,000	20,000	30,600	30,000
169	499240	50,500	61,600	17,500	27,500	34,000
170	545740	63,000	58,000	27,500	27,500	22,000
171	525769	62,000	62,000	27,500	30,200	22,000
172	519595	55,450	64,000	27,500	35,200	40,000
173	456285	52,950	62,250	25,000	34,400	32,000
174	548226	63,000	65,000	27,500	38,250	34,000
175	550723	58,500	62,850	22,500	29,800	26,000
176	27270	NA	71,800	NA	34,400	42,000
177	470906	49,425	63,000	25,000	44,800	38,000
178	523563	60,000	74,700	27,500	48,200	29,000
179	545792	64,000	65,000	27,500	34,400	41,000
180	517147	67,200	67,700	27,500	47,800	40,000
181	25424	NA	73,500	NA	53,200	33,000
182	495733	59,000	72,000	15,025	38,250	40,000
183	494103	66,550	66,550	25,000	47,000	40,000
184	524256	64,950	77,250	27,500	34,800	38,000
185	474175	68,950	78,500	25,000	62,000	55,000
186	495929	64,000	69,000	25,000	39,800	43,000
187	516244	76,450	80,000	22,500	59,300	58,000
188	479064	88,500	105,050	25,000	53,500	70,000
190	520621	73,000	76,450	27,500	37,500	46,000
191	540410	77,850	82,500	27,500	46,300	46,000
192	547369	75,650	71,000	30,000	39,000	56,000
193	521001	65,950	66,950	27,500	36,300	40,000
194	455932	53,000	68,250	17,467	45,900	37,000
195	25893	NA	60,250	NA	52,000	40,000
196	540227	61,450	66,000	27,500	42,100	41,000
197	570037	68,900	69,000	27,500	34,400	35,000
198	541358	61,250	67,350	27,500	42,075	45,000
199	25978	NA	65,900	NA	25,250	35,000
200	501033	55,500	64,200	27,500	28,300	37,000
201	537674	59,450	59,000	27,500	35,600	37,000
202	522524	58,000	60,450	15,000	37,500	41,000
203	516307	60,500	65,650	27,500	31,800	38,000
204	430629	52,500	54,500	25,000	34,400	42,000
205	542224	54,000	54,000	27,500	34,800	33,000
206	26525	NA	62,000	NA	29,100	27,000
207	547818	58,500	60,500	27,500	30,600	25,000
208	572856	65,000	63,000	27,500	28,300	36,000
209	524986	58,500	56,900	27,500	30,600	32,000
210	27397	NA	54,800	NA	33,700	28,000
211	471242	39,000	50,400	23,400	28,300	28,000
212	524855	46,600	49,000	27,500	26,000	36,000
213	541371	51,950	53,000	27,500	22,200	26,000
214	549065	50,500	53,450	20,900	26,800	30,000
215	545945	51,750	52,000	27,500	30,600	26,000
216	537159	45,500	51,085	26,370	21,800	20,000
217	26781	NA	60,950	NA	35,600	32,000

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
218	545835	52,000	54,000	27,500	30,600	28,000
219	550656	50,250	48,450	27,500	35,600	20,000
220	455367	42,500	48,100	25,000	35,950	27,000
221	525588	41,000	39,600	22,800	30,600	22,000
222	525309	39,900	41,200	23,940	22,950	22,000
223	540462	46,500	46,600	27,500	35,950	23,000
224	543817	42,500	47,000	25,500	22,950	13,000
225	548320	42,000	42,200	25,200	26,400	12,500
226	475315	30,000	41,000	18,000	30,600	16,000
227	449390	31,500	40,500	18,900	22,200	14,000
228	503053	45,950	46,000	27,500	27,900	21,000
229	26211	NA	47,000	NA	11,500	24,000
230	475914	30,000	39,800	7,500	20,700	14,000
231	25289	NA	36,000	NA	21,800	10,000
232	502140	43,400	45,000	26,040	18,000	25,000
233	496087	33,000	38,000	19,800	17,200	16,000
234	399987	35,500	20,000	11,970	19,000	12,000
235	498439	52,000	47,000	24,870	21,000	17,000
236	521398	37,000	36,500	22,200	20,600	18,000
237	543381	44,950	41,000	26,970	13,400	17,000
238	521833	31,875	31,750	17,880	19,100	13,000
239	492958	36,950	33,000	19,950	14,900	18,000
240	539573	23,600	23,600	14,160	11,500	7,000
241	26789	NA	21,000	NA	12,600	6,000
242	524141	31,500	33,800	18,900	15,300	9,000
243	553450	31,750	38,200	19,050	15,300	8,500
244	480863	31,600	29,150	18,960	14,500	7,500
245	497910	49,000	35,000	25,000	13,800	18,000
246	411917	25,000	35,500	15,000	13,800	13,000
247	514437	47,500	30,000	27,500	12,600	16,000
248	25858	NA	24,400	NA	10,700	16,000
249	410238	18,500	14,000	11,100	4,200	4,000
250	26443	NA	8,200	NA	1,912	4,000

Values for CRV and maximum guaranty are not available (NA) for vendee loan foreclosures.

Chairman **Murkowski**. The last question—and this is the last question. You have proposed that the GI bill benefits for all eligible Vietnam-era veterans, dependents and survivors will only be cut back 8.7 percent under the fiscal year 1986 sequester order. Why did you not balance the needed sequester savings for the readjustment benefits account so as to avoid the deeper cuts being taken from a program which is designed solely for the service-connected?

Mr. **Alvarez**. John.

Mr. **Vogel**. Mr. Chairman, are you speaking of the apparent disparate treatment of the vocational rehabilitation?

Chairman **Murkowski**. Yes.

Mr. **Vogel**. The reason for that is that in the Vocational Rehabilitation Program for service connected, disabled veterans, about 60 percent of the total amount in that program area is paid out to those trainees in the form of a subsistence allowance.

The other 40 percent of the total is tuition fees, books, supplies, et cetera, that are provided the educational institution and the training establishment. A great number of those are under contract.

We have signed agreements with universities, with apprenticeship programs to provide those benefits. So that administratively it would have been difficult to get out from under that. The thought was that if we reduced the amount of tuition fees and supplies and placed the difference on the back of the veteran, it would have driven the veteran out of the program.

So what we did was take a slightly deeper cut in the amount of subsistence, in the entire amount that would be available in tuition fees, supplies, et cetera, that would be paid by the agency.

Chairman **Murkowski**. Thank you. That concludes my questions. Gentlemen, I wish you a good day and I thank you very much for responding to our questions. We will look forward to further responses to those questions which have been submitted for the record. I wish you a good day.

[The questions and responses appear on p. 196.]

Chairman **Murkowski**. Our next witness will be Mr. Don Shasteen, Assistant Secretary for Veterans Employment and Training, Department of Labor. He will be accompanied by Mr. Joseph Juarez, Director of the Office of Veterans' Employment, and Mr. Jeffrey Crandall, Acting Director, Office of Field Operations and Administrative Services.

I call the committee hearing back to order and I call on Mr. Don Shasteen.

Secretary Shasteen, first, I want to commend you on responding to some of the prehearing questions that I submitted to you. How you got them through OMB I do not know, but more power to you.

Please proceed.

STATEMENT OF DONALD E. SHASTEEN, ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING, DEPARTMENT OF LABOR, ACCOMPANIED BY JOSEPH JUAREZ, DIRECTOR, OFFICE OF VETERANS' EMPLOYMENT, REEMPLOYMENT RIGHTS AND TRAINING PROGRAMS; AND JEFFREY CRANDALL, ACTING DIRECTOR, OFFICE OF FIELD OPERATIONS AND ADMINISTRATIVE SERVICES

Mr. SHASTEEN. Thank you very much, Mr. Chairman.

It is good to be back before this Committee in spite of the subject that we are discussing today. In order to make the best use of everybody's time and give the maximum opportunity to the people who follow to present their views, I am going to summarize rather quickly what I think is the main concern of the Committee, from my statement.

Our fiscal 1987 budget request is a net reduction of $1.45 million from the fiscal year 1986 appropriation. Yet, it provides adequate funding for all Congressionally-mandated Federal and State administered veterans' program positions.

The budget request reflects the fact that the special veterans' programs—that is the Disabled Veterans' Outreach Program, the Local Veterans' Employment Representative Program, and the performance standards imposed by the Assistant Secretary for Veterans' Employment and Training on the State-administered job service agencies have been relatively successful in reducing veterans' unemployment.

Our request is based on the perception of the unemployed veteran population that the greatest need is for employability development and supportive services to assist those most disadvantaged veterans.

That is to say, with Vietnam-era veterans' unemployment down below 6 percent, the proportion of non-job-ready veterans is higher than in the past. Therefore, to balance the need for services with the need for deficit reductions, our budget request features a requested increase in the Job Training Partnership Act, title IV–C funds for training and supportive services and maintenance of the Disabled Veterans' Outreach Program staff who are mandated by title 38 to provide comprehensive services to disabled veterans and disadvantaged Vietnam era veterans.

The decrease in local veterans employment representatives is justified by the fact that the State job service agencies have proven their ability to deliver services on a priority basis to the job-ready veterans who comprise most of the agency's veteran registrants. LVER's are primarily supervisors of the delivery of services but not the providers of services themselves. So, in light of the need for a deficit reduction, it seems most appropriate to take our reduction there. That concludes my summary, Mr. Chairman. I would be very happy to take any questions that you might have, beyond those that we have answered in writing.

Chairman MURKOWSKI. Thank you.

[The prepared statement of Mr. Shasteen appears on p. 79.)

Chairman MURKOWSKI. Does the "lack of need" for current staff levels of the Local Veterans' Employment Representative Program translate into an overall decrease in the use of job training programs in general?

Mr. SHASTEEN. We really anguished over that same question. Every one of us who has been responsible for working on this budget in our agency, and in the Department, has been looking for every feasible way that we could reduce expenditures without hurting those who depend on those expenditures.

In examining the facts, we have arrived at this logic, that the problem of supervising the delivery of services to veterans has been reduced substantially by the dramatic reduction in veterans' unemployment.

Chairman MURKOWSKI. What is that figure now?

Mr. SHASTEEN. The figure now is down to—for Vietnam-era veterans, 5.9 percent, which is below the general labor force figure of 6.6 percent.

Chairman MURKOWSKI. What is the figure for all veterans as opposed to Vietnam-era veterans? Is it lower or higher?

Mr. SHASTEEN. It is about the same.

Chairman MURKOWSKI. Well, I commend you for the evidence that veterans' employment programs have resulted in a substantial and evident decline in veterans' unemployment, as you have indicated.

Your fiscal year 1987 budget request provides for the continuation of the current staffing level for the Disabled Veterans' Outreach Program, and a reduction in the staffing level for the Local Veterans' Employment Representatives.

Is there a demonstrated lack of need for current staff levels? Several representatives of veterans' organizations have expressed concern that a decrease in staff will have an adverse impact on service to veterans.

Mr. SHASTEEN. What we have done is maintain the DVOP—Disabled Veterans Outreach Program—staffing level, at the level that is mandated, that is written in title 38: one for each 5,300 Vietnam Era and disabled veterans.

We have exercised the flexibility that is allowed by the law and by our regulations implementing that law for Local Veterans Employment Representatives.

The DVOPs provide direct service to veterans so we are not reducing the staffing levels of those employees who provide direct services to veterans. It is only in the supervision of the overall delivery of services to veterans by the local offices that we have taken that reduction.

The performance of the local offices nationwide has improved to the point where we believe now is a good and logical time to utilize the flexibility of the LVER law by reducing the number of supervisory personnel without reducing the direct services that our DVOP program provides to veterans.

Chairman MURKOWSKI. Last year in the Veterans' Job Training Act there was an extension?

Mr. SHASTEEN. Yes, sir.

Chairman MURKOWSKI. But you did not ask for any money this year?

Mr. SHASTEEN. The request for funding for that program comes in the VA budget. We have never requested funding for it. We are continuing to implement the program, through our DVOPs and LVERs, and by coordination with our Job Training Partnership Act funds to make it as successful as possible.

Chairman MURKOWSKI. In your opinion, do you think you should ask for additional funding or should the VA ask for funding?

Mr. SHASTEEN. Well, it's—we have not really been consulted on that, but there is $17 million remaining from the Emergency Program that the VA's General Counsel has ruled may be carried over to the Veterans' Job Training Program. We are pressing ahead with the program utilizing those funds before we make any decision to ask for further funds. We believe that since the first $150 million, which was provided more than 2 years ago, has not been totally utilized, we do not really have a basis for coming back to ask for more until we can prove that we can use the money that is already appropriated. We are pushing ahead with that; we are not delaying.

Chairman MURKOWSKI. We are going to let you off easy. I have no further questions.

Mr. SHASTEEN. Thank you.

Chairman MURKOWSKI. There may be some for the record, so we will alert you.

Mr. SHASTEEN. Thank you.

Chairman MURKOWSKI. Thank you and your colleagues.

We will proceed with the service organizations at this time. I want to note that Colonel Passamaneck, the National Legislative Director of AMVETS, will not be able to testify today. There was a death in his family. His father passed away. His full statement will be entered into the record. I extend condolences to his entire family.

[The prepared statement of Colonel Passamaneck appears on p. 84.]

Chairman MURKOWSKI. So, I am going to ask each of the service organization representatives to come up together. We will have one panel consisting of four service organizations represented by:

Mr. Paul Egan, deputy director, National Legislative Commission, and Mr. John Sommer, deputy director of the Veterans' Affairs and Rehabilitation Commission, of The American Legion;

James N. Magill, director, National Legislative Service, of the VFW, accompanied by——

Mr. PRINCIPI. Mr. Juarbe could not be here.

Chairman MURKOWSKI. Mr. Fred Juarbe is not able to be here today. He is the director, National Veterans Service, of the VFW.

Mr. Stephen L. Edmiston, deputy national legislative director, Disabled American Veterans, and Mr. R. Jack Powell, executive director of Paralyzed Veterans of America.

You may start in any order that you wish, gentlemen.

Mr. EGAN. I'll start, Mr. Chairman.

Chairman MURKOWSKI. Fair enough.

STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. EGAN. John Sommer and I are going to split our five minutes, if you do not mind; and I will cover the economic and labor issues, and he is going to cover the veterans' affairs issues.

First of all, with regard to the Home Loan Program, just a couple of words about the amount of authority that the VA has available to guarantee loans.

We have some serious questions about who is responsible for this gross underestimate that has put this entire program in the current bind that it is in. We certainly welcome the legislation that you and Senator Cranston have introduced to increase that authority, but we also have some concern about whether or not an authority of $18.2 billion will be sufficient to carry us through this year.

Now, Mr. Vogel has said that it will. We think that is probably a low estimate, and we wonder, in view of the VA's support of your legislation whether or not Mr. Vogel and the VA are going to be coming forward sometime in August if a further increase is needed.

Chairman MURKOWSKI. My attitude would be that if it is needed, we will support it, and we will get it.

Mr. EGAN. Very good. That is reassuring, Mr. Chairman.

With regard to the 1 percent tax that is imposed on veterans using this program, we do not think that tax ought to be increased. We do not think that it is consistent with this administration's policy on taxes. Instead, we suggest that that tax be converted into a one-time premium for mortgage insurance against short-term economic reversal.

On the subject of employment programs, first of all, the Veterans Job Training Act.

The reauthorization of VJTA that occurred last December began with a bill that was formulated in this committee, and we certainly expect this committee to take a leadership role in securing the appropriation that has been approved as part of that authorization.

In the Job Training Partnership Act, part IV-C is reserved for veterans, but out of an entire program costing $3 billion, we think that the $8 million that is allocated to veterans in part IV–C is inadequate.

Now, this year, under the 4.3 percent reduction imposed under Gramm-Rudman sequestration, some $416,000 will be cut on March 1, but in addition to that, a rescission request has been made to further reduce part IV–C by another $576,000.

Now, as part of the 1987 budget, a request has been made for an increase in IV–C of 20 percent, but given the very small portion of that entire jobs program that IV–C is, we think that it should be substantially increased; and, in that regard, Mr. Chairman, the Job Training Partnership Act is going to have to be reauthorized this year.

We think that it is appropriate for this Committee to become actively involved and actively interested in what Labor and Human Resources does with that reauthorization with a view toward expanding part IV–C and perhaps even requiring some veteran representation on PIC's and getting some programmatic inclusion in

Titles II(A) and III, which are the block grants, and the dislocated worker program.

The SBA has once again been proposed to be eliminated. Naturally, we do not agree with that, because, as part of that proposal, the Office of Veterans' Affairs would be completely eliminated; it is not slated to be transferred over to the Department of Commerce or anywhere else.

If the SBA, after all is said and done, is eliminated—and we think that it is appropriate for this committee to step in and see to it that that office is transferred to the Veterans Administration complete with direct loan authority, guarantee authority, and informational assistance.

I think I have probably expended my 2½ minutes, so I will turn it over to John Sommer at this point.

Chairman MURKOWSKI. Your suggestion is that the SBA be turned over to the VA?

Mr. EGAN. Only the Office of Veterans' Affairs, complete with the authority that the SBA veterans office currently has to make direct business loans, to guarantee business loans, and to provide informational assistance to veterans.

Chairman MURKOWSKI. But you would propose that it be limited to veterans only, is that right?

Mr. EGAN. There is, within the SBA, an Office of Veterans' Affairs, and it is charged with providing special consideration——

Chairman MURKOWSKI. You would have the SBA strictly responding to veterans' needs?

Mr. EGAN. Not at all.

What I am saying is that if the administration prevails and SBA is eliminated with some remaining functions transferred over to the Department of Commerce, the Office of Veterans' Affairs that currently exists within SBA be transferred to the Veterans' Administration. I believe that is where it was originated in the first place.

I am not saying that the entire SBA ought to be entirely devoted to veterans at all, if that is what your meaning is.

Chairman MURKOWSKI. Turn it over and put it under the Office of Veterans' Affairs. Then it continues to function?

Mr. EGAN. Those responsibilities that the SBA is currently carrying out for veterans are outlined pretty specifically in law. They are supposed to provide special consideration to veterans seeking to open or, begin their own businesses, and they are also required under current law to provide a fairly modest direct loan program.

As part of the overall SBA effort, and because there is an Office of Veterans' Affairs, there is a good deal of information available and distributed to veterans who might consider opening their own business.

We propose that that be transferred to VA if SBA is eliminated.

Chairman MURKOWSKI. I would like to have a little more information on your recommendations other than just a general reference to a concept, because SBA is a pretty good-sized organization as it is currently structured.

Mr. EGAN. Well, don't let me be misunderstood here, Mr. Chairman.

We are certainly not supporting the elimination of SBA. We are saying that if SBA is eliminated, the business program for veterans should be allowed to survive. That's all we are saying.

Chairman MURKOWSKI. Yes. Well, you are suggesting, though, that to make it survive it be moved over to the Veterans' Administration.

Mr. EGAN. Only in the event that SBA is ultimately eliminated.

Chairman MURKOWSKI. With respect to your earlier reference to an objection to the 1-percent origination fee increase and a reference that it should be converted into mortgage insurance. Have you done any evaluation to know whether a 1- or 2-percent origination fee would be adequate to purchase mortgage insurance?

Mr. EGAN. We are not interested in 2 percent.

Chairman MURKOWSKI. Either 1 or 2 percent—my question is whether you have collected any figures to indicate whether you could purchase mortgage insurance? Would that percentage be sufficient?

Mr. EGAN. That would be entirely dependent upon the duration of the short-term insurance, and the conditions under which it was purchased.

Chairman MURKOWSKI. Well, mortgage insurance is not short-term; it covers the term of your mortgage.

Mr. EGAN. Well, Mr. Chairman, the idea here is to address a question that you raised, and we think rather pointedly. When you were in the process of developing your legislation on housing last year, your concern at that time was what are we going to do to speed up the process of foreclosing upon people who have been in default for so long that they cannot possibly get out from under.

Our concern is what can we do to prevent those people in default from being foreclosed; what can we do to prevent those people who are up against the wall with high mortgage rates to prevent them from defaulting.

We think that short-term mortgage insurance is one way of approaching this problem.

But on the bottom line——

Chairman MURKOWSKI. Well, I do not think we are differing. My question is a mechanical one. Do you have any figures to indicate whether or not a 1-percent fee would cover mortgage insurance?

Mr. EGAN. I haven't any figures, but I would be very——

Chairman MURKOWSKI. Since you are working on this issue anyway, if you could provide us with that information we will pursue it too, OK?

Mr. Sommer?

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. SOMMER. Thank you, Mr. Chairman.

I will make just brief comments and will begin with the Department of Veterans' Benefits. The budget proposal reflects an increase of 400 FTEE; however, 362 of these are included in the Office of Data Management and Telecommunications that is being transferred into DVB.

I would like to point out that there were 918 FTEE cut from the Department of Veterans' Benefits in fiscal year 1986 and since fiscal year 1979, there has been a loss of 5,476 positions.

We are not convinced that DVB can operate effectively or efficiently at that projected level of employment. With respect to the Department of Medicine and Surgery, the levels of funding and staffing for medical care are certainly not acceptable. A decrease of over $46 million, and 7,542 FTEE inpatient care would emasculate the Department of Medicine and Surgery.

We fail to see OMB's rationale in attempting to justify the reduction of 6,988 of these positions by stating that a means test would eliminate "low-priority veteran care" by 62,000 inpatients and 1.3 million outpatients.

First off, we do not like the term "low-priority veteran."

Second, over 37,000 veterans a month are already being turned away from VA medical care, and for every veteran turned away by means testing criteria, if a means test were implemented, several veterans would be waiting in line to take his or her place.

We feel that OMB is illustrating another example of its distorted ingenuity. We trust that this committee will not let the VA medical care system be dismantled.

In medical construction the proposed reduction of $331.9 million would leave a construction budget that is anemic to the point of starvation. It is not wise to drastically reduce funding for medical construction when the capital plant of the VA is deteriorating.

It is distressing to us to see that there are only two replacement hospitals included in the projection; however, we are pleased to see that a replacement hospital in Baltimore is finally included.

In conclusion, we endeavor to leave the committee with the understanding that the American Legion considers the administration's budget proposal for VA to be unsatisfactory and we will be prepared and look forward to discussing specific problem areas with the Committee in the future.

Chairman MURKOWSKI. Thank you very much, Mr. Sommer.

[The prepared statement of Mr. Egan and Mr. Sommer appears on p. 97.]

Chairman MURKOWSKI. Mr. Magill.

STATEMENT OF JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. MAGILL. Mr. Chairman, thank you for the opportunity to present the views of the Veterans of Foreign Wars with respect to the President's proposed fiscal year 1987 budget for the Veterans' Administration.

We have all heard this morning the numbers that the Veterans' Administration is going to be expected to operate. We know that funding has been reduced and it is going to be very difficult for the VA to continue to provide quality care on the level they have been doing so in the past.

We would like to take a few minutes, not to rehash those numbers, but to express our concern as to how this reduction would affect the Veterans' Administration.

Unquestionably, this budget takes direct aim at undermining the VA's ability to provide adequate health care to all our Nation's veterans that seek such care.

What we are particularly concerned about is the reduction in outlays in fiscal year 1987 medical care programs of approximately $102 million, and the cutting of medical care staff of nearly 8,000 personnel.

This means over 1,300 nurses and 500 physicians will not be in the VA hospitals caring for the increasing patient care load.

Also, by the VA's own admission, over 57,000 fewer veterans will receive inpatient treatment, and there is also going to be a reduction of approximately 1.1 million outpatient visits.

One must keep in mind the VA is already turning away vast numbers of veterans each month. With respect to nursing home care, we commend the VA for increasing the grants to States for nursing home construction. We also commend the foresight, by converting a portion of their acute care beds to long-term care.

We understand, though, that only a net gain of 59 nursing care beds would be realized under this conversion plan. This equates to less than one-half bed per hospital, VA hospital.

We also would like to point out that the aging veteran will require increased acute care also, so the conversion strategy should not be allowed to undermine the VA's acute care capability.

In a related matter, we also question the VA's decision not to initiate new nursing home construction. In fact, the VA proposes to reduce its present 40 percent share of nursing home beds to 30 percent while increasing community involvement from 20 percent to 30 percent.

We believe the VA should be the primary supplier of nursing home care.

Of course, Mr. Chairman, we oppose veterans being charged a user fee in the Home Loan Guaranty Program, and it should be no surprise we are opposed to the proposed increase of 2 percent, which would gradually be increased to 3.8 percent by 1990.

We are also opposed to the redefining of eligibility requirements for those receiving the $150 plot allowance.

For the reasons pointed out in my written statement, the VFW is also opposed to the repeal of the new GI Bill. This program, in our opinion, is a proven success.

We were also asked to comment on the Department of Labor's Veterans' Employment programs, and I can honestly say that we are pleasantly surprised with the administration request for this function.

We do have a couple of concerns about it. We are concerned about the reduction of 231 Local Veteran Employment Representatives. We are also concerned about no funding for the Veterans' Job Training Act. The planned rescission of approximately $600,000 from title IV-C—and that is in addition to Gramm-Rudman—is, as I said, a real concern of ours.

Overall, though, we find the budget acceptable, and with the new initiative programs we are going to closely monitor this.

In closing, I would like to take this opportunity again, to state that we believe in almost in its entirety the administration's proposed fiscal year budget for 1987 for the Veterans' Administration is unreasonable and unworkable, and we look forward to working with you to try to guarantee that all our Nation's veterans will be able to receive the benefits and entitlements that they have earned.

This concludes my statement, Mr. Chairman.

Chairman MURKOWSKI. Thank you very much, Mr. Magill.

[The prepared statement of Mr. Magill appears on p. 129.]

Chairman MURKOWSKI. Mr. Steve Edmiston, deputy national legislative director, Disabled American Veterans.

Mr. EDMISTON. Thank you, Mr. Chairman.

Chairman MURKOWSKI. I welcome you to the committee and look foward to your testimony.

STATEMENT OF STEPHEN L. EDMISTON, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. EDMISTON. It is a pleasure to be here this morning on behalf of the more than 1 million members of the DAV and its ladies auxiliary to comment on the VA's 1987 budget.

Before I comment on that budget I would like to make a few comments regarding the Gramm-Rudman-Hollings balanced budget amendment sequestering provisions to take effect March 1.

Mr. Chairman, the DAV believes that the VA has grossly distorted the Gramm-Rudman-Hollings sequestering order to be implemented on March 1. For example, the VA has ordered reductions in direct benefit payments to service-connected disabled veterans and their dependants because they say Gramm-Rudman-Hollings must apply to every program.

Yet yesterday the VA announced they will continue to operate its home loan guarantee program without restrictions. Mr. Chairman, a review of other Federal agencies reveals that reductions required by Gramm-Rudman-Hollings on March 1 are not being applied to all programs.

Yet these agencies are meeting the dollar reductions under the provisions of that legislation. We must ask, Mr. Chairman, why the VA has not for example taken that 4.3 percent cut required of DVB out of administrative costs rather than reduce direct benefit payments to service-connected veterans.

How does the VA plan for example to reduce the payment for special adaptive equipment on the automobile of a double-leg amputee or a paraplegic. Will they only pay for hand controls and not pay for the automatic transmission?

Furthermore, with respect to reductions proposed for VA construction under Gramm-Rudman. It seems to us that it would make more sense to delay or cancel an entire hospital construction project rather than scale back several hospital and nursing home projects to meet the dollar savings required in the construction program.

It appears that the VA's approach to reducing the construction account under Gramm-Rudman-Hollings will in fact cost the Federal Government more money rather than truly save as is the intent of Gramm-Rudman-Hollings.

Mr. Chairman, when Congress adopted the Gramm-Rudman-Hollings balanced budget amendment last year, they made it perfectly clear that veterans compensation and pension would be exempted from the sequestering provisions of that legislation.

The DAV believes that VA has violated that exemption and we would urge you and the members of this committee to propose legislation to fully protect direct benefit payments to service-connected veterans and their dependants.

Since time does not permit me to detail our views on the 1987 budget request, Mr. Chairman, I would just simply say that the DAV strongly believes that the proposed 1987 budget request fails to provide adequate resources to provide medical care services for this Nation's service-connected disabled and poor veterans.

We would strongly urge the committee to recommend realistic levels of funding for medical care as well as all VA programs. We would like to thank you again for the opportunity to appear here this morning.

Chairman MURKOWSKI. Thank you, Mr. Edmiston.

[The prepared statement of Mr. Edmiston appears on p. 139.]

Chairman MURKOWSKI. You indicated in your opening remarks some reference to Gramm-Rudman-Hollings and the Home Loan Guaranty Program, and the fact that the VA had seen fit to go off and increase the origination fee. Is that basically what you said?

Mr. EDMISTON. Well, no. What I was referring to was that originally when the sequestering order was issued, the VA proposed implementing certain restrictions within that program. Yesterday they removed or indicated they were removing all those restrictions.

So it seems to us, the point I was trying to make was that they are not implementing the restrictions across the board as they so indicated, and we therefore feel that they have a means to provide some exemptions if you will to certain direct benefit payment programs.

Chairman MURKOWSKI. I understand that was really not the result of the sequester process under Gramm-Rudman-Hollings but, it was in response to the third quarter estimates of loan activity. Furthermore, the application of a guaranty is not an appropriation.

It may be called upon, but it is more of a contingent liability. I would differ with the implementation of that action and the requirements of Gramm-Rudman-Hollings, but that is a small point.

Thank you very much. Our last witness but not least by any means Mr. Jack Powell is the executive director of the Paralyzed Veterans of America.

Mr. POWELL. Thank you, Mr. Chairman.

Chairman MURKOWSKI. I look forward to your views.

Mr. POWELL. Thank you, sir. Our testimony has been submitted for the record so I will paraphrase a couple events.

Chairman MURKOWSKI. I have some idea of what to expect. Go ahead.

STATEMENT OF R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. POWELL. I do want to take a moment to touch on Gramm-Rudman-Hollings. I think it has been at least my understanding of the experience of Congress that no piece of legislation that ever gets passed the first time out ends up in reality being exactly what it was intended to be. There are always flaws and there are always glitches.

I cannot believe and I do not think that you, Mr. Chairman, or the members of this committee or most of the veterans organizations I know, nor most of the people in this country would ever have believed that it was the intent of Congress to cut 250 paralyzed or double amputee veterans out of $2,840 to use to buy an especially adapted house.

I do not think that was their intent, and I do not think that anybody around would ever begin to believe that cutting those 250 like that would do anything about the deficit or balancing the budget, and that is one example of a glitch that exists.

Another one that seems to be absolutely ridiculous is the idea that Gramm-Rudman-Hollings applies to nonappropriated funds such as the VA's canteen service which exists without the benefit of a single Federal dollar to buy or to provide the opportunity to veterans in nursing homes and hospitals and other isolated locations the opportunity to buy some creature comforts and goods. It runs off the profits it makes from those sales.

Those kinds of things I hope that at least this Committee will look forward to addressing as well if we are going to continue to have Gramm-Rudman-Hollings around, and I suspect in fact we will. In fact there are those who say that Gramm-Rudman-Hollings is a lot better for veterans than the President's 1987 budget as proposed.

I know that we live in a time when resources are restricted. I think perhaps however veterans have gotten to be where they are today because in fact contrary to public statements made by some members of the Congress of the U.S. veterans for the last several years have not run around saying more, more, more.

They have not done the screaming perhaps that veteran service organizations should have done in order to defend their membership from the realities that we see now. Maybe it is time for us to go back to the phrase that came out of a movie saying "I am mad as hell and I am not going to take it any more." I do not know.

I do know this, that just as an example of what went on here before with the VA panel when we talked about why a 13.1 percent cut is going to be placed on the subsistence allowance for service-connected disabled veterans obtaining vocational rehabilitation, trying to learn how to once again become productive members of this society. It was because it was easier to do that than try to renegotiate contracts signed with educational and rehabilitation institutions.

I submit, Mr. Chairman, that there was a contract signed between the United States, its Government and its people, and the veterans of this Nation who now are being denied benefits that they have been promised and were told they would receive.

When I look at the budget though I do not think we can just kick the President or OMB around because when I look at the budget I find things that do not make sense. It seems to be bureaucracy saving bureaucracy.

We hear for instance about productivity improvements. Productivity to me has always meant that we either do more with the same resources or we do the same with less resources, but when I sit down and I look at the number of patients treated proposed in 1987 and see that that is a 5-percent reduction over the number of patients treated in 1985, I do not want to deal with the 1986 numbers because nobody agrees to what those are.

I see the number of outpatients to be treated between 1987 and 1985 as a 5½-percent reduction, but I see that the average ceiling in employment has only gone down by 4.3 percent. Now, 4.3 percent is a tragic number and we all agree that that is too much.

But what we see here is that the loss of employees is significantly less than the loss of services to veterans. I go and I look at one other area in the medical budget which is medical miscellaneous benefits and services. I see that they take a 20.2-percent reduction in funding, some 70-plus million dollars.

In 1987 their proposed number of FTEE go up by 33. Why should it take more people to manage less money? I go down there and look at the Office of Construction. The Office of Construction takes a 41- or 40-percent cut proposed for 1987, and yet the FTEE grow by 6 percent, and the general administration budget to manage this 40 percent less fund grows by 13 percent.

I do not understand those things, and I guess I probably again must admit being confused. I also noticed that while we are cutting 7,400 health care employees out in the field, nurses and physicians and everyone else, while we are cutting 1,114,000 outpatient visits and 64,000 inpatient episodes, the cut to DM&S management here in the central office is nonexistent.

It amounts to, the minimal cut amounts to 73 people who are feedback, who are transferred to the Office of Construction, and then DM&S gets the Office of Construction back.

It seems like the only one who gets left out standing in the cold, whether it be by OMB submitted budget, or whether it be the VA submitted budget, ends up being the veteran who is still trying to get the help he thought he once had been promised. Thank you, Mr. Chairman.

Chairman MURKOWSKI. Thank you very much, Mr. Powell.

[The prepared statement of Mr. Powell appears on p. 149.]

Chairman MURKOWSKI. I think that some of those questions would have been appropriate for me to ask. I intend to extrapolate a little bit from the record and pose some of those questions with regard to the cuts in the administrative function of the VA which, as you have suggested, evidently are not in existence.

You indicated that vocational rehabilitation will be reduced by 13 percent pursuant to the sequester order. However, is it not true that nearly 40 percent or more veterans in VA vocational rehabilitation program have disabilities rated at less than 30 percent? In other words they are not severely disabled.

Mr. POWELL. I believe the numbers that you mentioned are approximately correct. It is not—if I may.

Chairman MURKOWSKI. Yes, go ahead.

Mr. POWELL. If we have a programmatic question, this, Mr. Chairman, I submit is the forum in which to handle that programmatic question. If we have a question, a debate, a difference of agreement on whether 10 percenters or 20 percenters, or 30 percenters or whoever ought to be eligible for vocational rehabilitation, I think we ought to do that here in the clear light of the sun.

I do not think at the midnight hour sending out a press release by turtleback express I guess, announcing our intention that on the first of March we are going to cut the subsistence allowance to everyone, a hundred or 10 percenters by 13.1 percent because God knows we do not want to go back and deal with the contracts with those educational institutions.

Chairman Murkowski. By the same token though, Mr. Powell, I think that you would share in the responsibility of the service organizations in making recommendations as to what is an appropriate percentage under the VA's vocational rehabilitation program.

Mr. Powell. Given the opportunity we would gladly do that.

Chairman Murkowski. But you have the opportunity.

Mr. Powell. Mr. Chairman, I believe——

Chairman Murkowski. You can use this forum or another forum. I have to ask for input.

Mr. Powell. We would be happy, Mr. Chairman, I believe to respond to you in writing on that question.

Chairman Murkowski. Fine. I would appreciate that. That input is needed since our position is one of constant review of policies that may not be as expeditious as prioritizations or reprioritizations of the process, when we are up against the realities that the budgetary process dictates.

[Not received at time of publication.]

Chairman Murkowski. I want to thank you gentlemen for your participation and your views, and for sharing your views. I wish you a good day. This concludes the hearing. There will be questions for the record. The record will be left open for the balance of this week and in through Monday.

Thank you.

[Whereupon, at 12:13 p.m., the committee was adjourned.]

APPENDIX

Statement by Senator John D. Rockefeller IV
Veterans Affairs Committee: The President's FY87 Budget for Veterans
February 20, 1986

Thank you Mr. Chairman. I know you and our distinguished colleague, Senator Cranston, look, like I do, at the weeks ahead as a difficult and trying time for this committee. The President has told us that he wants to save over $350 million in medical care for veterans, and proposes a range of cutbacks in other benefits. It is now up to us to respond, and decide what we think is a fair, adequate, and necessary spending plan for veterans in the next fiscal year.

I feel like a veteran of this committee, in the sense that the President's budget has a very familiar ring to it. Like last year, the Administration wants to impose a strict, and I believe intolerable, means test on veterans seeking health care at VA Medical Centers and facilities. They propose to continue shrinking the size of staff at these facilities, to the possible serious detriment of the the quality of care provided to the nation's veterans. And the Administration continues to oppose funding for the Veterans Job Training Act, even after Congress has passed legislation to expand and improve its predecessor, the Emergency Veterans Job Training Act.

Naturally, I primarily look at the President's budget as West Virginia's veterans would. I know, for example, how veterans dependent on VA medical care in the western part of my state will feel about the request to reduce the overall VA health care system by 9,000 people. These veterans generally use the Huntington VA Medical Center. A VA study recently submitted to Congress, assessing the status of five Medical Centers, found that the Huntington hospital has a "staff shortage of 23.7%, in contrast to the 9.2% national average of the entire VA medical care system." This strongly suggests that this hospital needs more staff, and can not bear any cutback.

Another program targeted for budget-cutting is beneficiary travel. I recognize that there may be many veterans who do not need to have their transportation paid for by the federal government in order to get to and from VA hospitals. But there are lower-income and physically-handicapped veterans in my state who say that they would not be able to get certain care prescribed by the VA if this assistance did not exist. For example, the Clarksburg, West Virginia hospital often sends patients to Pittsburgh for certain treatment. I think we should explore ways to ensure that this treatment is not denied as a result of a drastic change in beneficiary travel.

Finally, I would like to comment specifically on the the Administration's veterans employment proposals. Actually, I am most concerned with what is not proposed. I know that many veterans of West Virginia are hoping that the federal government funds an extension of the Emergency Veterans Job Training program. Among the 12.3% of West Virginians who remain unemployed, there are many veterans who could obtain critical skills training and take a major step forward towards long-term employment, if the $65 million that Congress authorized for this program is provided. I do not agree with the VA, which argues that the rise in the employment levels of veterans makes the Veterans Job Training Program unnecessary. I believe that this increase, which is a positive trend, has occurred precisely because of the assistance that has been provided in the past to veterans in need of job training and opportunities. We cannot abandon those with who are still unemployed, many of whom have the most severe problems in finding and staying in jobs -- the "hard-core unemployed."

I am somewhat skeptical of the Administration's willingness to work with the Congress in developing a federal budget that meets our obligation to cut the deficit, and sets appropriate and fair spending priorities. The proposed FY '87 budget for veterans is a good example of the Administration's stubborn insistence on trying to balance the budget on the backs of some of the most deserving segments of society.

I know this committee will fight for a fair budget for veterans. I pledge to play an active role in this effort, and I welcome the help of all of the veterans groups which are here today. We cannot run away from the problem of the country's staggering federal deficit. We need the help of veterans themselves to set priorities and spend less wherever possible. But at the same time, we will not tolerate cuts that jeapordize the health and well-being of those who gave so much to this country.

Statement of the Honorable Everett Alvarez, Jr.
Acting Administrator of Veterans Affairs

Thank you Mr. Chairman. Mr. Chairman and Members of the Committee. I am grateful for the opportunity to appear before you today to discuss the Veterans Administration 1987 budget.

As you are fully aware, the passage of PL 99-177, or the Gramm-Rudman-Hollings amendment, requires a balanced budget by 1991 with actions to be taken beginning in 1986 to achieve this long range balanced budget goal. I would like to point out that the Veterans Administration, in relation to other government activities, has again been treated fairly in the overall distribution of budgetary resources. The Compensation and Pensions programs are totally exempt from sequestration. The Medical Care account has been partially exempted from the full effects of sequestration.

With respect to the 1986 sequestration of administrative programs, we are considering a variety of options to achieve necessary outlay reductions. These options include staff reductions which could be pursued through attrition and reprogramming actions to avoid furloughs. A hiring freeze has been implemented. In addition, we are planning to reduce overtime, cash awards, employee travel, equipment, etc. to ensure the avoidance of any adverse personnel actions. These activities will be closely monitored by the staff of the Office of Budget and Finance and the Office of Personnel and Labor Relations. It is our objective to redistribute any savings realized to offices which are having difficulty in absorbing the reduction. A reprogramming between DVB GOE subactivities and GOE General Administration is anticipated and certain benefits accounts will also be candidates for reprogramming between sub-activites. Reprogrammings may also be proposed within the medical and construction activities. At this time, we believe that, as a result of these actions, we will be able to meet the reductions required by PL 99-177 while maintaining a continued high quality of service to our nation's veterans.

I will now summarize the VA's 1987 request.

This year's budget calls for $26.6 billion in new budget authority. This total comprises $25.6 billion appropriation request, $174.9 million for proposed legislation, and $801 million in permanent authorizations.

The following highlights the request for major accounts.

Compensation

The 1987 appropriation request for this account is $10.4 billion. This dollar amount is based upon an estimated veteran caseload of 2.2 million and a survivor caseload of 326 thousand. This caseload reflects a reduction of 14,500 veterans and 6,300 survivors from the 1986 level. The funding level includes the full year impact of a 3.1 percent cost of living increase that was effective on December 1, 1985. A program supplemental of $272 million is requested to support this cost of living increase in 1986.

In addition, legislation is proposed to provide a compensation cost of living increase of 3.7 percent on December 1, 1986. The cost in 1987 of this cost of living increase is estimated to be $305.5 million. It should be noted that the budget assumes no change in eligibility or the basic operation of the compensation program in 1987. The budget estimates include caseload projections based on current trends and cost of living increases based upon current economic projections.

Pensions

The 1987 appropriation request for this program is $3.8 billion. This funding level reflects a $10 million decrease from the 1986 current estimate. The dollar reduction reflects the continued decline in the pensions caseload. It is estimated that veterans caseload will decline 34 thousand to a level of 634 thousand and that the survivors caseload will decline by 63 thousand also to a level of 634 thousand. The dollar reductions resulting from the decrease in workload is partially offset by the cost of living increases included in the budget request. The 1987 request provides resources for the full year cost of a 3.1 percent cost of living increase provided on December 1, 1985 and the estimated impact of a 3.7 percent cost of living increase on December 1, 1986.

Burial Benefits and Miscellaneous Assistance

Under existing legislation, an appropriation request of $134.4 million is requested to support operations in 1987. The increase reflects a higher mortality rate of the aging veteran population as well as a return to the Title 38 benefit payments which were reduced in 1986 in order to achieve the savings required by sequestration of funds.

In addition, legislation will be proposed making the eligibility requirements for the burial plot allowance the same as those for the basic burial allowance. These benefits would be paid to veterans with a service-connected disability, veterans in receipt of a pension, and certain other categories of war-time veterans. Enactment of this legislation would save approximately $31.2 million in 1987.

Readjustment Benefits

An appropriation of $741.2 million is requested in 1987. This funding level reflects a decrease of $136.4 million from the current 1986 funding level. This decrease is due to a decline in trainees as more veterans either pass the 10 year delimiting date or exhaust their education benefits.

In 1986, a program supplemental of $91 million is requested to support higher education, training and specially adapted housing costs than can be supported by the 1986 appropriation. It should be noted that the $91 million program supplemental is required to support estimated operations of the current education program. This supplemental is not requested to offset the impact of sequestration on this program.

In addition, legislation is proposed to close the Peacetime Veterans GI Bill to new enrollees on October 1, 1986. This program was enacted primarily to assess the impact of expanded education benefits on the recruitment and retention of qualified personnel. The Department of Defense has determined that this program is not necessary for recruitment and may in fact, with the enhanced education benefits, provide an incentive to leave the military. The Post-Vietnam Education Assistance program, which matches servicepersons' contributions at a 2 for 1 rate, would be reopened to new enrollees on October 1, 1986. Although the Veterans Administration administers this program for the Department of Defense and the legislation is being proposed by DOD, the impact is included in the Readjustment Benefits and Post Vietnam Education Assistance program budget requests.

Loan Guaranty

No appropriation is requested for this account in 1987. Estimated obligations of $2.6 billion will be funded by $2.4 billion in offsetting collections, a transfer of $125 million from the Direct Loan Revolving Fund, and a $30 million decrease in unobligated balances.

The Administration will request, under proposed legislation, an increase to the current 1 percent funding fee to 2 percent in 1987, increasing in steps to 3.8 percent by 1990. Under this proposal, the fee would increase from 2 percent in 1987 to 2.5 percent in 1988, to 3 percent in 1989, and to 3.8 percent by 1990. The increase in the funding fee is a part of a government-wide policy to assure that programs like the Home Loan Guaranty program are operated on a sound financial basis. It is anticipated that the 2 percent fee would reduce outlays by $131.8 million in 1987.

General Operating Expenses

The budget request for General Operating Expenses is $763.5 million and 18,337 average employment for the operations of the Department of Veterans Benefits, the Department of Memorial Affairs, and the various staff functions of our Central Office.

The Department of Veterans Benefits (DVB) is requesting $515.5 million and 13,000 FTEE in 1987, respective increases of $46 million and 400 FTEE above 1986. These increases include $25 million for funding of a comprehensive six-year plan to modernize the benefits delivery systems for which preliminary steps were taken in 1985.

Total costs between 1986 and 1991 are estimated to be $155.6 million partially offset by expected savings of $87 million and 863 FTEE. Also included as DVB increases are $13.2 million and 362 FTEE which will be transferred from the Office of Data Management and Telecommunications to place ADP development functions and responsibility with DVB. This submission also proposes to achieve greater efficiency by closing the St. Paul Insurance Center and shifting that workload to the Philadelphia Insurance Center.

The Department of Memorial Affairs is requesting $44.2 million and 1,189 FTEE. This is $2.3 million and 13 FTEE above the 1986 level. It is expected that total interments will increase by 2.8 percent, gravesites maintained will increase by 2.5 percent, and headstone/marker applications processed will increase 2.7 percent over 1986 levels.

In the General Administration activity, the 1987 request is $203.9 million and 4,148 FTEE which is an increase of $2.5 million and a decrease of 377 FTEE from the 1986 level. Initiatives include PAID Redesign software development ($1.5 million), two surveys of veterans ($1.1 million), transfer of functions to DVB from the Office of Data Management and Telecommunications and staff to administer proposed legislation to permit reimbursements from health insurers under certain circumstances ($1.0 million and 25 FTEE).

Medical Care

The Medical Care appropriation request for 1987 is $9.1 billion, a decrease of $43.8 million from the 1986 level. The average employment of 185,192 is a decrease of 7,443 under 1986. Although workloads are projected to decline from 1985, this proposed budget will provide treatment for nearly 1.4 million inpatients and over 18.6 million outpatient visits.

The budget provides for other new or expanded initiatives such as the National Disaster Medical System (NDMS); Decentralized Hospital Computer Program (DHCP); Most Efficient Organization (MEO) Studies, Hospital Based Home Care (HBHC); Adult Day Health Care (ADHC) and Medical District Initiated Peer Review Organization Program (MEDIPRO). Facility activation resources have been provided for construction projects that are planned for completion and activation during the fiscal year. The most significant hospital activation replacement projects are Minneapolis, Minnesota and Portland, Oregon.

The 1987 budget includes legislation to require a means test for both veterans over and under age 65. Exempted from this reform would be service-connected veterans and certain other special categories of veterans. This reform would restrict the use of the medical system by non-exempt veterans whose income exceeds twice the VA pension level. This proposal assures fairness of access to care for non-service connected veterans both over and under age 65. The proposal also helps assure that non-service connected veterans who have the greatest need for our service receive a higher priority. Legislation is also included to obtain third party reimbursements for the cost of medical care and treatment for veterans with non-service connected disabilities. Third party reimbursements are estimated to be $187.5 million in 1987. In addition the budget proposes to restructure and enhance VA's long term care policy by increasing resources for non-institutional care programs, which would enable veterans to remain at home when appropriate, and for VA-supported state and community nursing home programs, which are less costly than VA-owned nursing homes. The request also provides for targeting travel funds for beneficiaries to provide only for emergency travel needs of veterans who need special transportation, such as an ambulance or a wheelchair van, to get to a VA hospital.

Medical and Prosthetic Research

The 1987 request for Medical and Prosthetic Research is $188.9 million and 4,266 FTEE, an increase of $7.8 million over 1986 and a decrease of 102 FTEE. Medical research will provide funding in heart disease, schizophrenia, spinal cord injury, diabetes, cancer, aging, alcoholism and related problems of Vietnam era veterans, former Prisoners of War and female veterans. Rehabilitation research funding will provide significant emphasis in priority areas of prosthetics/amputations, spinal cord injury and sensory aids. Health services research will continue its efforts in management and service initiated research and begin a study on an evaluation of the VA adult day health care program.

Medical Administration and Miscellaneous Operating Expenses (MAMOE)

The 1987 request for this program is $42.7 million and 591 FTEE. These amounts reflect the phasing out of the Health Professional Scholarship Program, the transfer of funding for the Office of Facility Engineering, Planning and Construction (FEPAC) to the Construction, minor projects appropriation, the transfer of funding for the Postgraduate and Inservice Training activity (except MAMOE central office staff training) to the Medical Care appropriation, and support for a physician staffing study, uncontrollable inflation and payroll increases, and other program support.

Grants For Construction of State Extended Care Facilities

The 1987 request for this program is $42.4 million, an increase of $21.6 over 1986. The increase will reduce the large backlog of unfunded projects and provide 120 additional nursing home beds; 126 convertible domiciliary and nursing home beds and 150 domiciliary beds in 8 states.

Construction

The 1987 request for the two construction appropriations totals $408.2 million. An additional $57 million, available from previous appropriations, will contribute toward a total program level of $465.2 million. Included is $415.5 million for medical facility projects, $3.6 million for the National Cemetery program, $5.0 million for the Staff Offices, $1.9 million for the regional office program, $300 thousand for the Emergency Fund, and $38.9 million for General Administration.

There are 10 projects in the major projects construction request. Design funds are requested for Dayton, OH, Bed Replacement and Modernization and North Chicago, Illinois, Environmental Improvements, Patient and Nursing Home Care Buildings. Construction funds are provided for the Baltimore, Maryland and Augusta, Georgia, Replacement Medical Centers. Two new clinical improvement projects are scheduled for Construction in Salem, VA and Salisbury, NC. The construction program continues to emphasize the correction of life safety and other code deficiencies.

This budget includes a proposed reorganization of our construction program which would delegate responsibility for construction to the Chief Medical Director. To accomplish this reorganization, 73 positions are being transferred from DM&S Facility Planning under the Medical Administration and Miscellaneous Operating Expenses appropriation to the newly named Office of Facilities, under the construction minor appropriation. To enhance overall project oversight, ten positions will be transferred from construction to the newly established Office of the Associate Deputy Administrator for Management and three positions will be transferred to the Office of Controller to enhance fiscal oversight.

This concludes my prepared statement, Mr. Chairman. My staff and I will be pleased to answer your questions regarding the 1987 budget estimates of the Veterans Administration.

STATEMENT OF DONALD E. SHASTEEN
ASSISTANT SECRETARY FOR
VETERANS' EMPLOYMENT AND TRAINING
FY 1987 BUDGET
SENATE VETERANS' AFFAIRS
COMMITTEE

Feb. 20, 1986

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to discuss with you the Fiscal Year 1987 Department of Labor Budget proposal as it pertains to veterans' employment and training programs.

Before I provide details about budget matters, I would like to mention a few items about which we in the Office of the Assistant Secretary for Veterans' Employment and Training (OASVET) and Veterans' Employment and Training Service (VETS) are especially pleased and enthusiastic. Making the OASVET the principal focus for administering veterans' programs within the Department has proven beneficial. The Vietnam-era veterans' unemployment rate (5.9%) now is below that of the general labor force (6.6%) in contrast to the situation four years ago. We believe improvements in the delivery of services have contributed to this progress.

For two years now we have operated a competitive grants program under the Job Training Partnership Act (JTPA Title IV-C), directed to meeting the needs of Vietnam-era recently separated, and service-connected disabled veterans. We have been, and expect that we will continue to be successful in meeting those needs for two major reasons: the programs are planned at the State and local level; and, the grant process encourages the use of local matching funds. These factors should also contribute to achieving maximum results for our investment. Thus far, through this emphasis on matching funds, we have awarded about 140 grants and have almost doubled the amount available for special veterans' programs.

We have also had the opportunity to implement the Emergency Veterans' Job Training Act (EVJTA) in cooperation with the Veterans Administration. This major effort by two Federal agencies has proven to be very effective in helping long-term unemployed veterans. To date approximately 42,000 long-term unemployed veterans have been placed. In FY 1986, we are implementing P.L. 99-238, the successor to the EVJTA. The newest feature of this program is the "case manager" concept, under which the State Job Service agencies' Disabled Veterans' Outreach Program (DVOP) and Local Veterans' Employment Representative (LVER) staff will take individual responsibility for ensuring the delivery of appropriate services to the program eligibles.

Additionally, we have seen improvement in the productivity of the State Job Service agencies for veterans as measured by the degree of priority delivered to veterans. The most recent national data available showed that veterans comprised 12.7% of all Job Service applicants, and 13.7% of all individuals placed by the State agencies.

In addition to the employment and training services administered by the agency, the VETS also provides services authorized by Chapter 43 of Title 38, U.S. Code, to protect the reemployment rights of veterans and reservists. Such rights include not only pay and seniority protections while the individuals are on active duty, but also protection of pension rights. With such protection, our national defense is enhanced since individuals, particularly reservists, would otherwise be reluctant to risk their full-time civilian jobs in order to serve in the military. Through efficient utilization of agency staff and emphasis upon settling cases through mediation rather than litigation, the agency is reducing case processing time, responding to more inquiries, and achieving resolution of more cases than in the past.

Overall, it is accurate to say that the Department is providing better services, more cost effectively, to veterans now than in the past, and that veterans' unemployment is declining significantly.

Our budget request for Fiscal Year 1987 is $131.5 million. Included in this amount is $118.4 million for grants-to-States, of which $69.5 million is for DVOPs and $48.9 million is for LVERs. The funding is for 279 Federal positions and 3,474 State agency positions allocated through grants-to-States.

The agency's request for DVOP and LVER funding is based upon the intention to maintain DVOP staff levels in accordance with the staffing formula set forth in Section 2003 A of Title 38, U.S.C. DVOP staff provide direct services to veterans, as prescribed in the U.S.C., and one position is allocated for each 5300 Vietnam-era and disabled veterans residing in each State. These specialists are mandated by law to provide employment and employability development services to the most disadvantaged veterans, e.g., the disabled and Vietnam-era veterans with severe barriers to employment.

LVER staffing will be reduced based on a demonstrated lack of need. Local Veterans Employment Representatives do not provide services directly to veterans to the degree that DVOP staff do, but instead are responsible for functional supervision of local offices' services to veterans. Since State Agencies are exceeding their quantitative performance standards, there is not the need for as much supervision as is now provided. The agency will provide funding for approximately 213 fewer LVER staff years in FY 1987 than in FY 1986. This will be effected primarily by reducing positions from full-time to a part-time basis in an estimated 450 local offices. The actual number affected will, of course, be dependent upon the actual position costs for FY 1987.

Emphasis will continue in FY 1987 on DVOP and LVER involvement in intensive job development and placement activity. In addition, these specialists will continue their efforts in coordination with service providers under the JTPA, community-based service organizations, and other supportive service agencies to ensure the provision of comprehensive services to veterans.

For the JTPA Title IV-C program administered by the agency, the competitive grant application system for award of grants to the States and/or Service Delivery Areas will continue. The budget amount for Veterans' Employment Programs under JTPA, Title IV, Part C, is $10.5 million for FY 1987. As you are aware, Mr. Chairman, this funding level is determined by a formula contained in the Job Training Partnership Act. As I stated earlier, we expect that we will continue to have an effective program due to the competitive structure and the preference given to those applicants that match or exceed the grant amount with local funds.

In closing, I would like to thank you for this opportunity to discuss the FY 1987 budget and how it affects veterans' programs. I am confident that with the requested budget we can continue the progress toward secure employment for all veterans and reservists, who with their dependents comprise approximately half of our nation's populace. I will be pleased to answer any questions you may have.

Statement of

DAVID J. PASSAMANECK

AMVETS National Legislative Director

Before The

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

On

The President's Proposed Budget for the Veterans'
Administration and the Department of Labor's
Veterans' Employment and Training Program
for Fiscal Year 1987

9:30 a.m., February 20, 1986 - Room SR-414

Mr. Chairman, AMVETS is pleased to address the President's proposed Fiscal Year 1987 Budget for the Veterans Administration's and the Department of Labor's Veterans Employment and Training Programs.

In the summer of 1980, when President Reagan was running for the office, he inspired the veterans' community in an address to a national veterans organization convention in Boston, by promising that the earned entitlements of veterans and their dependents and survivors would not be undermined, regardless of his commitment to reducing the excesses of government spending and an ever increasing tax burden. At the same time, the President clearly set forth a basic principle of his philosophy of government, when he stated, as he did again in his State of the Union Address this year, that the most important function of government is to defend its citizens from the aggressive purposes of foreign enemies. Although the President has declared his awareness of the special status of veterans in our society, his administration has repeatedly failed to recognize that the programs established for the rehabilitation and benefit of those who have "borne the battle" are an integral and morally compelling part of the cost of national defense, as much as the cost of current military hardware. Although the defense and veterans budgetary categories are technically separate, the Veterans Administration's budget cannot be lumped together with other domestic programs not related to the powers and responsibilities of national defense. The

President has rightfully and courageously advocated the continued recovery of our defense capability, tragically weakened in the wake of the shameful sell-out of our ally and over 58,000 of our fighting men and women in Viet Nam. However, when it comes to paying the solemn debt we owe as a nation to those who came back from that war and the World Wars and Korea as well, the special earned place of veterans is forgotten.

Almost from the inception of this Administration, the voices of fiscal conservatism, exemplified by the Grace Commission, have been calling for what amounts to the dismantling of the Veterans Administration and the essential services it provides for veterans and their families. In addition to the privatization of the finest medical delivery system in the world, the plans call for an almost total elimination of the contact, advisory, and adjudicative services upon which veterans must depend in securing those benefits which the law provides as well as elimination of all medical care for nonservice-connected veterans and eventually for those whose disabilities are not attributable to armed conflict or instrumentality of war.

AMVETS has consistently and enthusiastically supported the President's clear-headed leadership in the area of national defense. We are among the first of the veterans organizations to vigorously support the Strategic Defense Initiative, and we believe its increasing funding is the most vital imperative for our physical survival as a nation and for the survival of freedom in an increasingly hostile world in which we face the most ruthless, repressive and heavily armed adversary in history. We believe, as the President does, that to equate our defense requirements with the multifaceted mixture of often nonessential and unproductive government domestic spending ventures is to invite national suicide. By the same token, we refuse to accept the proposition that we can provide for an adequate national defense and at the same time betray the sacred obligations which we owe to our veterans, as well as our active and retired military personnel. Anyone who has the most superficial knowledge of military history, understands that ultimately wars are fought by people, and that if the legitimate needs of those who serve are ignored or forgotten, the most sophisticated machinery for the delivery of destruction to an enemy, or for our defense will avail us little. We are right now paying a terribly expensive price in terms of the continuous loss of trained military people to the private sector, not so much because of inadequacies of current compensation, as because of the demoralizing effect of promises and obligations to our veterans which are conveniently ignored in a misdirection of our otherwise legitimate efforts to cut the cost of goverment. So long as the President's defense policies do not include priority fulfillment of our obligations to our veterans, those policies are sadly inconsistent and to a considerable degree, self defeating.

In order to objectively assess the perilous condition in which we find our veterans' entitlement programs as we consider the VA budget for FY 1987, we must first recognize the complete breakdown of the national budgetary process, at least as a function of intelligent, discriminating and purposeful endeavor. This past October, AMVETS responded to the initial version of the Gramm-Rudman-Hollings Amendment in letters to Senators Gramm, Rudman and Hollings by stating:

> If the Gramm-Rudman-Hollings Amendment is designed as a serious response to the economic and political realities of the budgetary quagmire, then we are in worse trouble than even the most pessimistic of us had imagined. The amendment appears to be based on two premises: That if the Congress is politically incapable of controlling spending, then the ball should be passed to the President; and that, with the exception of Social Security, all other budgetary programs are of equal value. In addition to these fundamental assumptions underlying the Amendment, subsumed in its terms is a tacit acceptance of tax increases as a possible escape from the dilemma.

AMVETS, as we have repeatedly maintained in resolutions adopted by our national conventions and testimony before Congressional committees, strongly supports those policies which seek to control government spending, control inflation and interest rates, and perpetuate the economic prosperity which we are now enjoying. No segment of the population suffers more acutely from economic instability than veterans and their families, many of whom are dependent on minimally sufficient disability compensation and pensions. We have seen the disastrous impact that excess government spending and its attendant deficits has had on the usually depressed employment situation of our younger veterans.

However, we specifically reject the cynical concept that all government programs, except the politically untouchable, equally deserve to be cut in order to comply with a predetermined deficit limit.

Any program to control budget deficits which ignores the essential priority of expenditures for national defense, including veterans entitlements, is completely unworkable and constitutes a dangerous threat to our very existence as a nation.

The constant actual level of expenditures for veterans' entitlements has been steadily decreasing over the past decade, while most other government programs have literally gone through the ceiling. Completely unnecessary drains on the Federal treasury, such as the Synthetic Fuels Corporation, as well as the Energy and Education Departments, the elimination of which the President promised to seek in 1980, go marching on, but the benefits earned by those who have made the sacrifices demanded in the defense of their country are subjected to across-the-board economizing without any accounting for comparative merit.

AMVETS believes that veterans should come first in government funding and last when budgets are cut. It is unfortunate that the Gramm-Rudman-Hollings Amendment fails to subscribe to this basic standard of civic decency.

Together with the immediate impact of Gramm-Rudman-Hollings on VA services and programs, the President's proposed FY '87 budget threatens the most drastic curtailment since the early days of the Great Depression of the 1930's.

Just prior to presenting the Fiscal Year 1987 VA Budget, the Administration took a number of devastating steps to fundamentally set the course of long establisned and essential veterans entitlements on a downward path, as a result of a 4.3 percent across--the-board cut in federal spending. Effective March 1, 1986, the following cuts have been imposed:

- VA Home Loan Guaranty Program -- The VA will cease honoring requests to refinance VA-guaranteed home loans at prevailing lower interest rates. Further, they will no longer restore previously used entitlements nor issue partial entitlements above amounts already issued. In addition, veterans purchasing homes that cost more than $90,000 will not receive the "no-down-payment" guarantee.

- Benefit programs for veterans and eligible dependents and survivors enrolled in education and training programs will be reduced 8.7 percent.

- Grant payments made to seriously disabled veterans for specially adapted housing will be lowered by 7.9 percent--from $35,500 to $32,660.

- The survivors of more than 200,000 deceased veterans will see an average 10-percent cut in basic burial and plot allowances--including the service-connected death allowance--as well as in headstone or marker allowances.

- At least 20 positions in the VA's Medical and Prosthetic Research Programs will be cut and selected research projects will be delayed or canceled.

- Employment levels in the VA's Department of Medicine and Surgery will be cut 1,306.

- Subsistence payments for disabled veterans enrolled in vocational rehabilitation training programs will be reduced by 13.1 percent.

- Grant payments for automobile and adaptive equipment for disabled veterans will be cut 7.9 percent--from $5,000 to $4,600.

These cuts will result in a reduction of approximately $234 million in VA spending authority for FY 1986, before the additional 1987 cuts are even considered.

For Fiscal Year 1987, the Administration requests a VA budget authority of $26.6 billion, which is about $408.4 million below the current estimated authority for FY 1986, notwithstanding a proposed 3.7 percent cost-of-living increase for compensation, pension and DIC, effective December 1, 1986. Under Gramm-Rudman-Hollings, compensation, pension and DIC are specifically exempt from mandatory across-the-board cuts. In addition, at least 40-percent of the nondefense items in the overall budget have been exempted from Gramm-Rudman-Hollings. Thus those nonexempt areas will be forced to shoulder an extremely disproportionate share of the cuts. The massive impact of these cuts falls on the cost of operating the Department of Medicine & Surgery and Veterans Benefits.

The requested authority for DM&S of a little more than $9 billion represents a cut of $46.1 million from 1985 levels, including more than $134 million from hospital care. More than 7,500 professionals will be cut from DM&S, including more than 1,300 nurses and more than 500 doctors, with a projected additional cut of over 15,000 by 1991. In other words, the Grace Commission will have its way, and this budget is its blueprint.

This budget proposal means a cut of 1.1 million in outpatient visits, and about 60,000 inpatients, in the face of a current turn-away rate of about 30,000 veterans a month. We are also looking at a bed level cut of 2,700, modified by the addition of about 500 nursing home beds previously approved, and by expanding existing facilities. Overall construction will be cut some $332 million, resulting in the cancellation of seven previously planned nursing homes. In addition all beneficiary travel funds, except emergency mode transportation will be cut, resulting in a decrease of over $95 million in funding authority.

In order to supposedly make these cuts in medical care, without a decrease in quality, the Administration proposes what amounts to a drastic cut in nonservice-connected eligibility for health care. Despite the approval of a modified means test in the 1986 budget reconciliation which AMVETS and most other veterans organizations have endorsed, the Administration has again proposed the more drastic, wholesale version which was rejected last year. They now talk of treating fewer "low priority nonservice-connected veterans" regardless of their ability to meet the requirements of even the stringent means test.

The DM&S budget seeks a massive shift of nursing home care to state and community (read private) nursing homes, even though such facilities are not available in many areas of the country. The adoption of this budget will set the entire VA medical delivery system on a rapid course to extinction, thus destroying what over 55 years of heartbreaking struggle has built into a living monument to the pride and gratitude of a free people for the sacrifices of those who shouldered arms in defense of the nation. We cannot live with this budget, or the selfish, narrow-minded, penny-pinching philosophy on which it is based.

The proposed cuts in the Department of Veterans Benefits (DVB) are highlighted by a near termination of the Home Loan Guaranty Program. As if the restrictions imposed under Gramm-Rudman-Hollings were not enough, the Administration proposes increasing the user fees incrementally from the current 1-percent to 3.8-percent by 1990, with no new funds requested for the Loan Guaranty Revolving Fund, in strict compliance with the Grace Commission recommendations. Perhaps the most shocking proposal affecting nonmedical entitlements would result in killing the highly successful All Volunteer Force GI Bill for educational benefits. That this proposal should come from a President and a party which stands against reinstitution of the peace-time draft is, again, a striking example of the tragic inconsistency of the Administration's defense policy, as well as its callous betrayal of our veterans. And, finally, after this vicious attack on the benefits of living veterans, the Administration proposes taking away the $150 plot allowance for the burial of all 22 million honorably discharged wartime veterans and limiting that allowance to approximately 3 million veterans eligible for burial allowances.

AMVETS is mildly relieved at the modest proposed cuts for operation of the Office of the Assistant Secretary of Labor for Veterans Employment and Training of some $559,000 with a total reduction of FTEE's of about 279. We can live with this proposal.

We are, however, extremely disappointed in the lack of proposed funding for the Emergency Veterans' Job Training Program, even though this may be partially offset by a modest increase in the funding under the Job Training Partnership Act.

AMVETS subscribes completely to the following reaction to this Budget of the distinguished Chairman of the House Committee on Veterans Affairs, Congressman G. V. (Sonny) Montgomery:

> It is now more crucial than ever that veterans rally, get into the thick of things, write, make phone calls, and resist attacks on their programs, especially those made

through the budget process. The most important thing I can say to any veteran right now is join a service organization and get active; if you're already a member, stay active. It's the most effective tool you've got to help yourself and your fellow veteran, and it's essential to those of us on Capitol Hill who need to carry your input and your concerns through the halls of Congress.

This concludes my statement. I will be pleased to answer any questions regarding these matters.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

on

FY 1987 BUDGET

February 20, 1986

Mr. Chairman and Members of the Committee:

The American Legion appreciates this opportunity to present its views on the proposed funding for the Veterans Administration following an initial appraisal of the budget submitted by the Administration for fiscal year 1987.

The President has proposed for the Veterans Administration, Budget Authority of $26.615 billion, down more than $408 million from FY 1986, and Budget Outlays of $26.353 billion, down over $185 million from FY 1986.

It would appear on preliminary review that there is no need to worry about a sequestration order under the Balanced Budget and Emergency Deficit Control Act of 1985 being triggered if the funding levels contained in this proposal were enacted. The proposed VA Budget is so meager that it would certainly fall under the deficit ceiling established by Gramm-Rudman. However, more than $234 million in budget authority has been slashed from the already anemic current year VA Budget as a result of the President's order implementing Gramm-Rudman. Thus the funding levels reflected for FY 1986 on which the changes for FY 1987 are based are the revised/reduced figures. Therefore, it is necessary that comments on the adjusted FY 1986 budget are woven through this statement in order to truly illustrate the impact the dramatic reductions that have been proposed will have on benefits and services for veterans.

Mr. Chairman, before addressing specific aspects of the budget, we feel it necessary to set forth The American Legion's long-standing philosophy on the funding of veterans benefits and programs, and to reiterate briefly the contributions that veterans have made to reducing the Federal deficit over the past several years, through sacrificing benefits and services.

But first, it must be said that the problem we now face is much deeper than budget cuts. The issue is whether the Administration and the Congress will break faith with the nation's veterans and try to balance the Federal Budget on the backs of the men and women who left their homes and families when they were called upon to do so by the elected government in order to keep this nation free, and to defend the interests of the United States.

The recognition of the special contributions of veterans - and their unique rights and privileges - could be no more eloquently stated than was done by Supreme Court Justice William H. Rehnquist in a landmark decision of the high court affirming the unfettered right of veterans to petition the government. He stated in the May 23, 1983 decision as follows:

> "Veterans have been obligated to drop their own affairs and take up the burdens of the nation, subjecting themselves to the mental and physical hazards as well as the economic and family detriments which are peculiar to military service and which do not exist in normal civil life.
>
> "Our country has a long-standing policy of compensating veterans for their past contributions by providing them with numerous advantages. This policy has always been deemed to be legitimate."

We are aware that the Congress is subject to the intercession of a myriad of special interest groups, each seeking funding for their special programs - most of which are no doubt worthy.

You will pardon us, however, if we insist that among all the special interest groups, veterans are entitled to stand first in their claim on the attention of the Congress. As we stated earlier, veterans are those men and women who have served the nation, in uniform, in time of war and periods of active hostilities. It is a postulate that the nation cannot and must not turn its back on those who defended it - not if it expects an enthusiastic response to the next national emergency. It goes without saying that in the present state of international affairs, that emergency could well develop at any time.

It should also be pointed out that in the event of a total mobilization, many of those who served during the Vietnam war would be required to serve again - just as many World War II veterans were required to return to service during the Korean War.

If the Government expects that kind of patriotism and dedication from its veteran citizens, then it had better not ignore them in peacetime.

The American Legion is totally committed to veterans, and stands for full funding for veterans programs; by which we mean there should be provision of such funds as are necessary to effectively carry out the programs that have been established by Congress. We support all of those programs. Each of them had a purpose when enacted, and each has been adequately justified as meeting a legitimate need of the veteran population. We are not aware of any programs at present that are superfluous or redundant; and therefore, we support all veterans programs that are now functioning.

Veterans are responsible citizens and The American Legion is a responsible organization. In that respect, we have shared the concerns of the Executive and Legislative branches of the Government about the ominous budgetary deficits that face this country. In viewing this problem as responsible taxpayers, veterans have done more than their fair share in acceding to reductions in Veterans Administration benefits and services. During the four previous fiscal years alone, the savings to the Government that have resulted from these reductions have amounted to well over a billion dollars.

The portion of the total Federal Budget consumed by veterans programs has been declining consistently for the past eleven years. In FY 1975 the VA Budget represented a full 5 percent of the total Federal expenditures; in 1981 - 3.2 percent, and in FY 1986 - before the Gramm-Rudman cuts - 2.6 percent.

The time has now come to hold the line.

The fact is, Mr. Chairman, the proposed Veterans Administration Budget is unacceptable. In the judgement of The American Legion it is little short of disastrous.

Before providing comment on several specific budget items, which will be done for the most part in reference to the departments of the VA that administer them, we shall first address the legislative proposals set forth in the Budget Message. They are a collection of old ideas and new proposals, some of which seem to ignore the expected demand for essential benefits and services.

LEGISLATIVE INITIATIVES

# The Administration recommends a cost-of-living adjustment of 3.7 percent in compensation to be effective December 1, 1986. The position of The American Legion is that these COLAs should be at least consistent with increases in the Consumer Price Index. The proposed 3.7 percent increase for the service-disabled - the most deserving of all Federal beneficiaries - is consistent with the current rate of inflation.

# A change in the eligibility for the plot allowance, to make it consistent with the eligibility requirements for basic burial allowance is proposed. The American Legion is adamantly opposed to this idea. We feel that Congress made a mistake when it restricted the criteria for burial allowance. We are mandated to push for the restoration of the former eligibility criteria for the burial allowance to all veterans, and to increase the amount of the plot allowance.

# An initiative to increase the loan origination fee under the VA Loan Guaranty Program is included in this proposal. We are opposed to the increase in the loan origination fee from 1 percent to 2 percent with phased increases to 3.8 percent by 1990. This is a reincarnation of the plan that Congress rejected last year. We believe there are other means of assuring the solvency of the Loan Guaranty Revolving Fund, and we are prepared to work with the Congress in developing them. The user fee cannot be

viewed as anything other than a tax upon a traditional and economically useful benefit. The fee particularly impacts veterans with low to moderate incomes who would never be able to afford a home except through this program, as well as active duty military personnel whose families must periodically relocate.

# Proposed legislation would repeal the authority that permits VA to make education loans. Although an earlier cost-savings measure, the Omnibus Budget Reconciliation Act of 1981, limited the number of individuals eligible for VA education loans, those who retain eligibility and who depend on these loans could be forced to discontinue their program of education or training. Thus, The American Legion opposes this initiative.

Another Administration proposal would provide resources for the establishment of a means test in order to change the eligibility criteria for medical care for nonservice-connected disabled veterans regardless of age. The Administration proposal would, among other things, rescind 38 USC 610(a)(6), a provision of PL 91-500 authorizing that the Administrator, within the limits of Veterans Administration facilities, may furnish hospital care or nursing home care, determined by the Administrator to be needed, to any veteran sixty-five years of age or older for a nonservice-connected disability.

The American Legion is opposed to the establishment of a means test for nonservice-connected veterans regardless of age. We believe that an updated demographic profile, which we have sought from VA for over a year, would prove a means test to be ineffective. Available information indicates that most of the veterans that use the VA medical care system are old, sick and poor. If forced out of the VA system these veterans would have to resort to Medicare, Medicaid, other publicly supported institutions, or go without treatment at all. The implication that the VA system is crowded with affluent veterans is a myth. To subject those veterans who do seek treatment from VA, even before determining whether there is room for them in a hospital, would in our judgement not be cost-effective from the standpoint of the technical and administrative burdens it would impose on the hospital, and would discourage many of those veterans from applying in the first place. That of course is exactly what the proposers of the means test are hoping will happen, because it will decrease the demand for care on the system. The fact that these veterans may well be thrown back onto some other form of tax provided public support or receive no care at all is of little concern to the proposers of the means test. However, it is of great concern to The American Legion.

# The Administration has again proposed legislation relative to third party reimbursement for cost of medical care and treatment to veterans with nonservice-connected disabilities. This proposal would provide resources for the VA General Counsel to recover or collect the costs of such care from health insurance carriers. This plan, if enacted into law, would be a significant departure from the present, almost universally followed practice of health insurance

providers to deny benefits for care given in Federal institutions. Apparently, the health insurance industry doesn't think this idea is constitutional. We think it is a bad idea that would do irreparable damage to the VA medical care system. Our objections to third party reimbursement are several, the first being that in essence, veterans would be paying for their VA medical care through health insurance premiums. If third party reimbursement were implemented the VA health care program would be changed in its essential nature from a benefit to a cost sharing medical plan, and it would soon become difficult if not impossible to defend the continued existence of the VA system, as against merging it with Medicare.

- A new proposal would close the All Volunteer Force GI Bill to new enrollees, and reopen enrollment in the Chapter 32 (VEAP) program. The American Legion is mandated to support a peacetime GI Bill and has worked diligently for several years toward the enactment of such a program. Although the program that was established did not entirely satisfy the intent of our mandate, it is an improvement over the VEAP program, which never achieved a high participation rate, and a large number of those who did enroll later dropped out of the program. The Legion strictly opposes this initiative.

DEPARTMENT OF VETERANS BENEFITS

The direct benefit programs administered by VA through the Department of Veterans Benefits will consume 58.9 percent of the total VA Budget. These are, for the most part, the entitlement programs that must be funded, and they are meeting the real needs of the veteran population they are intended to serve.

These benefits are administered through 59 regional offices. The proposed budget reflects an increase in average employment in DVB of 400 FTEE. However, this figure includes a proposed transfer of 362 FTEE from the Office of Data Management and Telecommunications (ODM&T) into the Department. Thus, the actual increase for DVB projected for FY 1987 is 38 FTEE.

Mr. Chairman, since FY 1979 the average employment in the Department of Veterans Benefits has been slashed by 5,476 FTEE, including 918 that were cut in the current fiscal year. Of the 918, Gramm-Rudman accounted for 431 of those positions lost this year. The proposed level of employment for FY 1987 would be 12,790, which includes the 362 FTEE from ODM&T.

The American Legion must again advise this Committee that the Department of Veterans Benefits cannot continue to accept consistent and persistent personnel reductions year after year. This will inevitably impact on the ability of DVB staff to complete action on cases and disburse benefits, and thus severely hamper the delivery of services to VA beneficiaries. The timely delivery of benefits to veterans, their dependents and survivors is the most important responsibility of the Department, and the quality of work performed by personnel assigned to DVB determines to a great extent whether beneficiaries do in fact receive the benefits to which they are entitled by law. The American Legion's concern is projected from the standpoint that VA beneficiaries are either those with service-connected disabilities, their survivors or the aged and infirm seeking pensions. All are persons who very much need the benefits they are seeking, many on an urgent basis.

The American Legion is supportive of economy of personnel in management, and maximum productivity by all Federal employees. However, the complexity of veterans claims has increased due in part to issues such as the effects of exposure to Agent Orange and ionizing radiation, and the pathology of post-traumatic stress disorder, just to name a few. The more complex the issue is the more man hours required per case.

A certain minimum of personnel is needed to properly process cases, without delay-causing errors that have to be corrected; and productivity can only be used as a relative guide when considering the amount of work that must be done in the processing of a single case for an award of benefits.

Mr. Chairman, we firmly believe the Committee should press for precise data and information from VA before inflicting further loss of field personnel on the Department of Veterans Benefits. The American Legion is not convinced that the Department of Veterans Benefits can operate effectively or efficiently at the projected level of employment.

DEPARTMENT OF MEDICINE AND SURGERY

The American Legion is very much aware that the most sensitive area of the Veterans Administration Budget is the medical care program. The reason for this is that unlike the entitlement programs that are statutory in nature, the strength and efficacy of the medical care program depends directly on the appropriation of funds by Congress.

The Administration's proposal for medical programs for FY 1987 is slightly over $9.3 billion, representing 36.5 percent of the total VA Budget. This represents a decrease of more than $25 million below the current fiscal year funding.

Direct medical care consumes the largest part of this funding at slightly over $9 billion. Under this proposal the funding for direct medical care would be decreased by over $46 million below the FY 1986 level, which was decreased by $117.6 million due to Gramm-Rudman. Thus the proposed medical care funding for FY 1987 is actually $161.6 million below the amount that was included in the original FY 1986 budget.

Medical care funding over the past several years has been increased only marginally, and has not kept up with the rate of inflation. The level of funding for patient care proposed for FY 1987 is not acceptable to The American Legion. The proposed reduction in funding would severely hamper the ability of VA to provide quality health care to veterans. The hard fact is that if present trends continue, the system, as we have it now, is going to be dismantled.

The Administration's budget also includes a net personnel reduction of 7,542 FTEE in medical care. The Gramm-Rudman adjustment in FY 1986 effected a reduction of 1,306 FTEE, for a total proposed loss of 8,848 over the original employment level for FY 1986.

The proposed personnel reductions for FY 1987 are to be achieved, according to the Office of Management and Budget, by treating fewer "low priority" veterans, and through a one percent productivity increase.

Mr. Chairman, The American Legion is totally opposed to any further reductions of health care professionals. Personnel reductions based on inadequate funding and the implementation of programs such as the reduction of grade GS 11 through 15 positions in the Department of Medicine and Surgery have already had a severe impact on the VA's ability to provide quality medical care to veterans. The medical care system cannot absorb the reductions that are being insensitively forced upon it by OMB, and the staffing situation now existing within the system is critical. Morale is low. Recruitment and in many cases retention of employees in some critical positions has become almost nonexistent because of the lack of potential for promotion. DM&S is already reeling under the impact of the illogically conceived grade reduction initiative.

Now OMB, illustrating another example of its distorted ingenuity, is attempting to justify the reduction of an additional 6,988 FTEE by stating that the implementation of a means test will reduce "low priority" veteran care by 62,000 inpatients and nearly 1.3 million outpatient visits in FY 1987, thus eliminating the need for these positions.

It would appear that OMB is not aware that over 37,000 veterans a month are already reportedly being turned away from VA medical care facilities, and that for every veteran that would be denied care based on means testing criteria, several would be waiting in line to take his or her place. We simply fail to understand OMB's rationale on this issue.

It is the considered opinion of The American Legion that any further reductions in staffing will result in total and irreparable damage being wrought upon the VA medical care system, and bring about the beginning of the end of the provision of quality medical care to veterans as we know it.

The proposed maintenance of average operating beds in the VA system reflects a loss of 2,700 acute care beds, no change in domiciliary beds and an increase of 500 nursing home beds, for a net loss of 2,200 beds.

The number of acute care beds within the system has continually eroded over the past several years, despite the precautionary statements presented by The American Legion that there should be no further reductions. Since FY 1981 4,900 acute care beds have been eliminated - and that does not include the decrease of 2,700 beds proposed for FY 1987. As we have stated, this is a particularly bad time to be eliminating acute care beds, when aging veterans are increasingly experiencing catastrophic illnesses. Older persons almost always require treatment for an acute episode prior to the need for long-term care. It is obvious that there is a need for more long-term care beds in the system. However, that does not connote a decreasing need for acute care beds. The VA medical care system must maintain a substantial number of acute care beds if it is to retain its ability to meet the full mix of treatment needs required of it by its primary mission, and its ability to fulfill the agency's assigned mission as the principal contingency back-up to the Armed Forces medical programs in case of a national emergency or an outbreak of hostilities.

We are supportive of the proposed increase of 500 nursing care beds, which brings the system-wide total to 11,700. Nursing care beds in the VA system are always in demand, and there is usually a waiting list. A consistent increase in nursing care beds is strongly indicated.

We note that the beneficiary travel program is targeted for a reduction of over $95 million, and the program is to be "reformed" to provide reimbursement only for emergency transportation such as ambulances, air ambulances and wheelchair vans. We are extremely concerned that this will prohibit many poor veterans who do not reside near a VA facility from receiving needed medical care.

Medical and Prosthetic Research

An increase of $7.8 million in research funds is projected for FY 1987, up to $188.9 million. It should be noted that the original appropriation for medical research in FY 1986 was reduced by $1.5 million as a result of Gramm-Rudman.

Included in this research proposal is nearly $3.5 million for the continuation of the Centers for Disease Control studies on Agent Orange, Vietnam Experience and Selected Cancers.

The Medical and Prosthetic Research Program in the Department of Medicine and Surgery is of special interest and concern to The American Legion. This is because we are keenly aware of the importance of research in the triad of the VA health care program: clinical care, education of health manpower, and research. None of the three elements can thrive without the presence of the other two. It is unquestionable that VA cannot continue to provide high quality medical care to veterans without a strongly funded research program. Much of the research in which VA engages is basic research that is advantageous not only to veterans, but to all mankind. Equally important is the fact that a strong and viable research program ensures the recruitment and retention of high quality physicians into VA service.

A projected summary of average employment reflects a loss of 147 FTEE in Medical Research, and increases of 20 and 25 FTEE in Rehabilitation Research and Health Services Research, respectively, for a net loss of 102 FTEE. The budget document does not reflect how these losses are to be accomplished, but we are extremely concerned, especially because this appears to be a trend. In FY 1985 there were 4,551 FTEE in research, as compared to 4,266 projected for FY 1987. We maintain that there is a need not for a reduction, but for an increase in available personnel for VA research activities. The Federal Government could make no wiser an investment than ensuring a vigorous and viable VA research program that benefits the entire American people.

Grants for Construction of State Extended Care Facilities

An increase of $21.5 million, up to $42.4 million is proposed for grants for construction of State Extended Care Facilities.

We are extremely aware of the importance of the services provided by State Homes, in that they have substantially reduced the burden that otherwise would have been borne by the Veterans Administration.

As of May 1985 there was a total of 47 facilities and 3 annexes located in 34 states.

The American Legion considers this program a wise investment, and when considering the current efforts to reduce Federal spending, the role of the State Homes becomes even more significant.

The FY 1987 request will provide for four projects which will produce 120 nursing home, 126 convertible and 150 domiciliary beds, as well as 12 non-bed producing renovation projects in eight States.

In examining this program we note that there is currently a backlog of 69 projects representing requests for grants of over $168 million. What this means is that if a State submits a request for a grant for funding of a project today, it may receive funds five to six years in the future. As we move into the period of an aging veteran population that will be with the nation for the foreseeable future, the States can be of major assistance to the Federal Government in caring for this population through State Extended Care Facilities. However, in order to materially ease the pressure on the VA, adequate funding must be provided to the States so that proposed projects may be completed.

The American Legion realizes that the proposed increase in funding for FY 1987 will be helpful. However, in view of the backlog of requests, we question whether it is sufficient. Many States are taking positive steps to care for their aging veteran populations, a fact that is most commendable. However, it deserves the full support and encouragement of the Federal Government. This program is a most cost-effective way for the Federal Government to meet its obligation to veterans.

Grants to the Republic of the Philippines

The Budget message provides a grant of $500 thousand to the Veterans Memorial Hospital in Manila to replace and upgrade equipment and to rehabilitate the plant and facilities. This grant has been made by the United States consistently since the end of World War II. The Veterans Memorial Hospital cares for many Filipino veterans who served in the Allied cause during WWII. There is certainly an obligation by this country to continue to show our gratitude and concern for them. The American Legion has always supported this grant, and continues to do so.

MEDICAL CONSTRUCTION

The Administration's Budget recommends a reduction in the medical construction program of $331.9 million down to $415.5 million, for FY 1987. That figure includes $57 million of prior budget authority that is being reprogrammed from the major working reserve.

Mr. Chairman, so far as The American Legion is concerned, this proposed construction budget is anemic to the point of starvation.

It is just not wise to drastically reduce the funding for medical construction when the capital plant of the VA health care system is deteriorating. The reasons for this deterioration are several. There are still hospitals in the system that were built long before WWII. Others built immediately following WWII have deteriorated and have become outdated by medical technology. One of the primary reasons for this degeneration is the fact that the renovation and replacement program was underfunded for several years, which has forced VA to play catch-up in attempting to upgrade and replace these facilities. VA has been making up for lost time and some progress has been made in recent years. However, the facilities have aged while nothing was being done, and costs have escalated.

The projects that are included in the major construction proposal are a replacement medical center in Baltimore; a replacement medical center in Augusta, GA; bed replacement and modernization at the Dayton, Ohio VAMC; fire and safety improvements at Wood, WI; environmental improvements, patient and nursing home care buildings at North Chicago; outpatient, clinical and nursing unit addition, Salem, VA; geropsychiatric building, Salisbury, NC; electrical distribution, Salt Lake City; renovate buildings 10 and 90, Waco, TX; and a research and education building, White River Junction, VT.

We must say that we are extremely pleased that the Administration has finally come around to the point of view that has been espoused by The American Legion since the mid 1970's with respect to the need for a replacement hospital in Baltimore.

We are extremely concerned about the Administration's "plan for the future" that dictates no new independent nursing home care unit construction, and greater reliance on State Veteran Homes and community nursing homes. The nursing care formula currently in use consists of 40 percent VA, 40 percent State Homes and 20 percent private sector nursing homes. The new plan calls for 30 percent VA, 40 percent State Homes, and 30 percent private sector facilities.

This proposal of a new long-term care policy that emphasizes the use of community nursing homes is not really a new concept. The American Legion has opposed this idea in the past for several very good reasons. We do not disagree that community nursing homes play an important role in VA's effort to provide nursing care to veterans. However, there are certain postulates that must be taken into consideration.

It has been stated by some that the costs of constructing and operating VA nursing home care units are higher than those in the private sector. It must be realized that these government owned and operated facilities have rigorous obligations placed upon them to provide optimum quality medical care to veteran patients. Ongoing oversight is provided by the Congress, The American Legion and other veterans organizations, and by the VA itself through its Professional Services. Community nursing homes are not subjected to such thorough and constant policing. In addition, the VA nursing home patient load has a high percentage of veterans who because of the care they require are frequently not acceptable to community nursing homes. Veterans in VA nursing home care units are usually sicker and stay longer than individuals in private sector nursing homes and, therefore, they require more specialized facilities and equipment for their care. The community nursing homes are commercial ventures and many times refuse such cases because they are not profitable.

As for the replacement and renovation projects scheduled for FY 1987, based on the reports of our Field Representatives who make site visits to all of these facilities, we can assure the Committee all of the work scheduled is needed, and much of it is long overdue.

However, it is distressing to see that only two replacement hospitals are included in this projection. The Office of Management and Budget is only fooling itself by delaying the funding for badly needed projects. This is false economy, pure and simple, and will end up costing more in the long run, rather than saving the Government money, because the longer the projects are delayed the more it will cost to build them. And in the meantime the capital plant continues to decay.

Allowing this system to deteriorate makes no sense at all and, in fact, contradicts the Administration's position on national defense when one considers that VA medical centers constitute the principal contingency resource to treat returning casualties during a national wartime emergency.

It is obvious to The American Legion that Congressional intervention is the only possible solution to this abominable situation.

EXCESSING OF VA LAND

Included in the Budget proposal submitted to Congress by the Administration is notice of intent to declare excess and transfer to the General Services Administration, 109 acres of land that are presently part of the complex that comprises VAMC West Los Angeles, VAMC Brentwood, the VA Domiciliary and the National Cemetery operated by the VA Department of Memorial Affairs. This entire complex includes a total of 545.5 acres.

The original grant of the land that comprises these various VA activities was made in a deed executed by the owners of the land in the year of 1888. The land was gifted by the owners to the Federal Government to be used for the construction and operation of a Home for Disabled Volunteer Soldiers. Such a home was constructed and maintained, and through the years the original activity has changed, expanded and been modified until we see that today the entire complex comprises a variety of activities carried on by VA for veterans.

As the City of Los Angeles has expanded the land comprising the VA complex at West Los Angeles has become exceedingly valuable real estate. We can attest that all the VA land is coveted by the City of Los Angeles, by the University of California at Los Angeles (UCLA), and by developers who could make millions of dollars if they could gain control of that land, or any part of it. Additionally, oil has been found on some of the land, and the proceeds from the oil well now pumping there has provided substantial sums of money for the welfare of the patients at VAMC West Los Angeles. It is worthy of note here that the courts have held that the proceeds of the oil well cannot go to the Treasury of the United States, but can only be used for the direct benefit of patients being cared for at the VAMC. This decision is based on the terms of the deed that conveyed the land to the United States in 1888.

The American Legion of California has long entertained an apprehension, shared by the National Organization of The American Legion, that sooner or later a move would be made to attempt to gain control of some or all of this land, as it is described in these paragraphs. We see in this initiative to transfer 109 acres of the land to GSA, the first move in this direction. The value of the land in Los Angeles County being what it is, and human avarice being what it is, there is no way some move would not be made to dispossess sick and disabled veterans from such valuable land to the end of putting a lot of money in somebody's pocket - here we refer to developers.

If the transfer proposed in this budget initiative is accomplished, we of the Legion have reason to believe that the heirs and descendants of the owners who gave the land to the U.S. for the specific purpose of caring for sick and disabled veterans may very well undertake court action to invalidate the original deed and reclaim the entire complex of land. The resulting value of such an action, if successful, would be profitable to the claimers beyond the wildest imagination of most of us.

It is the earnest hope of The American Legion that the Committees of Congress, having oversight responsibility for the welfare of the nation's veterans will not permit the proposed transfer of land to take place. The American Legion will continue to oppose the transfer of any portion of the land herein discussed to anybody, for any purpose other than to continue to provide care for veterans. We petition this Committee that the first thing that must be done is to obtain from appropriate legal authority an opinion on the language of the original deed of transfer of 1888, and an interpretation of the legal authority the United States may have, or may not have, to dispose of any portion of the land included in the original deed of transfer.

In addition to that, we wish to state for the record that the complex of land described herein encompasses a wide variety of activities for the care of perhaps the largest single concentration of veterans to be found in the nation. We do not know whether there is any more oil on the land or not; but if there is the proceeds from its reclamation should be reserved for the welfare of veterans, as intended by the original conveyors. There is no possibility that the scale of veterans activities now being carried on at West Los Angeles will be in any way scaled down for the foreseeable future.

It is our petition to the Committee that this initiative be blocked by the Congress before irreparable damage is done to the interests of the veterans of the Los Angeles area.

DEPARTMENT OF MEMORIAL AFFAIRS

The funding proposal for the Department of Memorial Affairs reflects an increase of slightly over $2.2 million up to $44.2 million for FY 1987. An additional $3.6 million is identified for cemetery construction projects which is down $6.9 million from this fiscal year. The projected average employment for FY 1987 is 1,189 which reflects an increase of 13 FTEE.

The American Legion feels that the proposed funding for the Department of Memorial Affairs appears adequate. We totally support the construction program that is underway. We continue to work with the Department in attempting to acquire land for the expansion of existing national cemeteries.

It is our perception that the total Memorial Affairs program is progressing in a satisfactory manner. We are convinced that the program has improved immeasurably since it was placed under the jurisdiction of the Veterans Administration. We commend the progress that is being made, and trust that the Congress will continue to support VA's plans with the modest funding required to carry out this program.

VA HOME LOAN PROGRAM

Mr. Chairman, a great concern to us is OMB's blatant manipulation of the Loan Guaranty Program's credit limit, both in the proposed 1987 Budget and in the Gramm-Rudman sequestration for FY 1986. Despite evidence that the decline in interest rates was creating considerably more demand for credit under the program, OMB determined that the credit limit to be sequestered in the first round of Gramm-Rudman was $12.1 billion, which the sequestration process reduced to $11.6 billion. This determination came after the VA reported a first quarter credit usage of $4 billion, which annualizes to $16 billion. As a result, for the first time in its history, the VA has been forced to place an administrative limit on the size of individual loans it will guarantee. The reduction amounts to slightly under 20 percent, or $20,000. This reduction will force veterans buying homes in high cost-of-living areas such as Los Angeles, Philadelphia, Alaska and Washington, D.C. either to pay substantial down payments or forego buying a home. This will amount in effect, to a red-lining of many of our major metropolitan areas. Moreover, the VA has also been forced to prohibit refinancing of existing loans. This Committee has shown considerable concern over the program's rising default and foreclosure rates during the past several years, brought about chiefly by veterans who purchased homes during the recent period of property value escalation and soaring interest rates. To preclude these financially strapped veterans from reducing their high housing costs through refinancing of their loans invites a continuation of the foreclosure problem this Committee has been attempting to address for several years. It is poor program management and bad government.

Having dealt with this problem in 1986, it is inexplicable why the Administration is now proposing a credit limit in FY 1987 of $13.9 billion, in the face of what VA officials concede will be a demand for $18 billion. Undoubtedly the same or similar ill-advised and destructive limits established for FY 1986 will have to continue into FY 1987. In our opinion it is the surest way to undermine the VA Home Loan Program.

The American Legion urges this Committee to take a hard look at how these artificially low credit caps were established and to take the necessary action to establish realistic limits.

VETERANS EMPLOYMENT AND TRAINING

Of principal concern to The American Legion is the fate of the Veterans Job Training Act (VJTA) which the Congress, with the support of this Committee, passed two months ago. We note that the VA's Budget for FY 1987 does not include the $65 million authorized under the new legislation for the conduct of the program. This comes as no surprise, since FY 1987 will mark the fourth successive fiscal year in which OMB has attempted to bury this program through lack of funding. We have spoken on a number of occasions of the chronic structural unemployment problems experienced by Vietnam Era veterans, and the same conditions exist today as those which prompted the Congress to pass this legislation, in the face of Gramm-Rudman, two months ago. We trust that this Committee intends to honor the commitment it has made to unemployed and underemployed Vietnam Era veterans by working with your colleagues on the Budget and Appropriations Committees to assure that adequate funding is provided to carry out the program as Congress intended. With less than $17 million remaining in carry-over funds for VJTA, we urge swift action to guarantee the uninterrupted conduct of the program.

Mr. Chairman, we are pleased to report to you today that the Administration's proposed budget for the basic veterans program functions at the Department of Labor, with a single exception, appears adequate for the Department to carry out its legislatively mandated responsibilities. In our estimation, greater funding should be provided to State Employment Security Agencies in order for them to function as an effective labor exchange. In the context of the present deficit problem, however, it appears that the proposed FY 1987 budget provides sufficient funding to maintain the integrity of the Job Service.

We are particularly gratified to note that funding for the Job Training Partnership Act (JTPA), Title IV(c) will be increased, by ~~80~~ 20 percent under this proposed budget. In that regard, Mr. Chairman, we would like to point out that JTPA will undergo legislative changes this year and we hope that the Committee will work with the Labor and Education Committee to improve the participation of veterans in the overall program. While a $1.8 million increase in Title IV(c) funding is a positive step for veterans, it pales into insignificance when compared to JTPA's $3 billion in resources. We hope that the errors which resulted in the virtual exclusion of veterans from JTPA in 1982 will be corrected by this Congress.

A moment ago, we mentioned that the proposed 1987 budget for veterans employment functions at the Labor Department seemed adequate with a single exception. That exception is the line item for Local Veterans Employment Representatives (LVERs). The FY 1987 budget proposes to reduce the number of funded positions by 275 from its FY 1985 level, and 125 positions from the FY 1986 Gramm-Rudman level. The reason for this reduction is a change in regulations which eliminates consideration of local office veteran population in determining whether there is a need for a full-time LVER. Instead, the Labor Department would depend solely on local Job Service office activity, i.e., the number of veterans registered or renewed in a given year. This single criterion is, by its very nature, regressive, and will discourage many local office managers, experiencing staff cuts in other areas, to permit Disabled Veterans Outreach Program (DVOP) and LVER staff to conduct the outreach required by law. The regulations reward offices with minimal contact with the veteran community by allowing them to assign LVERs to other, non-veteran duties. The FY 1987 budget reflects the inevitable reductions in the number of full-time LVERs. The Committee needs to review the present statutory language in chapter 41, title 38, U.S.C., to make certain that the standards for a full-time LVER reflect both usage of the local office by veterans as well as their presence in the community as potential Job Service clients.

SMALL BUSINESS ADMINISTRATION

Although not under the jurisdiction of the Veterans Affairs Committee, we would like to call to your attention the proposal in the Administration's 1987 budget to eliminate the Small Business Administration (SBA). As you are aware, for many years the VA was responsible for providing small business loans and loan guarantees to veterans. With the creation of the SBA, the VA phased out this function, and today the responsibility for assisting veterans desiring to own small businesses rests solely with the SBA. Despite a history of neglect of veterans needs, the SBA in the last several years has been considerably more responsive to veterans. At the present time, about 25 percent of its loan guarantees are made to veterans. In addition, the SBA has established a viable veterans affairs office and now provides guidance to prospective veteran business owners. Under the Administration's budget for the next fiscal year, the SBA would be eliminated, and the veterans affairs function, rather than being transferred to another agency, would be completely done away with. We believe that the Committee needs to examine this situation and take appropriate action to assure that veterans entering the world of small business will continue to receive the guidance and support they deserve.

CONCLUSION

Mr. Chairman and Members of the Committee, in this statement we have set forth the positions of The American Legion on a variety of subjects that are included in the Budget Message of the Administration for the VA which we consider to be of special importance to the nation's veterans. We have spoken to those programs we believe to be of highest priority in an agency whose activities are all of high priority, because they are intended to respond to the needs, first of those who were disabled in war service, and then to the reasonable needs of all those who served honorably when called to do so by the nation.

As has been stated to this Committee on many occasions, it is the position of The American Legion that when the national priorities are established, funding for veterans programs should rightfully rank second only to national defense.

The proposed Veterans Administration Budget for FY 1987 contains many serious shortfalls. Despite the fact that veterans benefits and services, unlike most other domestic programs funded by the Federal Government, do not consume an increasing share of the Federal dollar, the Administration has proposed drastic and unacceptable changes in the Veterans Administration and in the services it provides.

It is our considered opinion that the Department of Medicine and Surgery would be emasculated if the cuts in funding and staffing that have been set forth by OMB are enacted. However, you may be assured that The American Legion does not plan to stand by idly and watch that happen. A long-sought goal of this organization was achieved in 1946, with the complete reorganization of the VA medical care program, and the establishment of the Department of Medicine and Surgery within the Veterans Administration. This was a major step in creating what is now the finest medical care program in the world. It must not be destroyed in the name of fiscal austerity.

We must say to this Committee, in all seriousness, that if that happens, the Congress will live to regret it. If there is a war, the cost of rebuilding and rehabilitating the veterans health care program would be far more than it will cost to maintain it now.

The approval, by Congress, of the severe reductions in VA programs set forth in this Budget would most certainly send a message to the nation's veterans that they have become a burden to the Government they served. We further predict that if the citizens of the United States see the Government break faith with the veterans of earlier wars, there will be a measurable lessening of enthusiasm in the support of national policies that involve the risk of American casualties.

We endeavor to leave this Committee with the understanding that The American Legion considers the Administration's request for funding of all programs administered by the Veterans Administration to be unsatisfactory. We have offered specific comment on those areas in which we feel there are the most glaring inadequacies, and we have addressed each of the legislative initiatives with respect to the concerns of this organization.

We trust the Committee will examine and consider the problem areas we have identified. As time and opportunity permit, we will be prepared and look forward to discussion and dialogue with the Committee about the various veterans programs that will be under consideration during this session of Congress.

Mr. Chairman, we appreciate this opportunity to present the views of The American Legion.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

THE PRESIDENT'S PROPOSED FISCAL YEAR 1987 BUDGET FOR THE VETERANS ADMINISTRATION

WASHINGTON, D. C. FEBRUARY 20, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before this distinguished Committee to present the views of the Veterans of Foreign Wars of the United States with respect to the Fiscal Year 1987 budget for the Veterans Administration as proposed by the President.

According to the Administration, on September 30, 1985, there were approximately 27.8 million veterans, 49.4 million family members of living veterans, and 2.1 million survivors of deceased veterans. While obviously only a portion of these people will be utilizing the many VA benefits and entitlements available to them, the VA must be prepared to adequately meet these needs. In addition, that population's life expectancy is rising because of modern science

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and medicine. As a result, the Veterans Administration is on the threshold of having to accept new challenges in providing benefits and entitlements to those eligible. It is for these reasons the VFW finds the proposed fiscal year 1987 VA budget severely lacking in the basic funding levels to provide for this challenge and preserve the integrity of the total VA system.

Mr. Chairman, as you know, the budget proposed by the President for the Veterans Administration for the fiscal year 1987 is $26,600,000,000 in budget authority. This figure represents a decrease of $408,000,000 from the current fiscal year. In outlays for fiscal year 1987, the President proposes a spending level of $26,300,000,000--down $185,000,000 from the current fiscal year. In order to be consistant and avoid confusion, my testimony will address the outlay function of the budget.

In what appears to be a disappointing (and what very well may be disasterous) trend, the VA's portion of the Federal budget continues to shrink year after year. The VA's proposed budget outlays for fiscal year 1987 is only 2.6 percent of the total outlays of the Federal budget--the lowest percentage in recent history.

Unquestionably, this budget takes direct aim at undermining the integrity of the VA's ability to provide adequate health care to our nation's veterans. Let the numbers speak for themselves. The outlays for fiscal year 1987 medical care programs would be $102,400,000 less than provided for in fiscal year 1986. Existing medical care staff would be cut by nearly 8,000 personnel. This is in addition to the $120,400,000 and 1,340 personnel reductions just recently placed into effect as a result of Gramm-Rudman-Hollings. This means that a grand total of over 1,300 nurses and almost 500 physicians will not be in VA hospitals caring for the increasing patient load. This budget proposal requires that 57,354 fewer veterans receive inpatient treatment from the VA and proposes a further reduction of 1.1 million in outpatient visits during fiscal year 1987. The VA estimates that up to 37,000 veterans are already being turned away each month from VA health-care facilities.

Mr. Chairman, at a time when the Administration is voicing concern about the aging veteran and its obligation to provide extended care, we find it curious the budget proposal does not properly address this concern. There is no new VA nursing home construction provided for in the budget. In fact, the VA proposes to reduce its present 40 percent share of nursing home beds to 30 percent. While we certainly commend the VA's attempt to address this problem by initiating the conversion of a portion of their acute-care beds to long-term care beds, however, we believe greater emphasis should be placed on this effort. It is our understanding only a net gain of 59-nursing care beds would be realized under the conversion plan. Taking into consideration, there are 172-VA hospitals, this equates to .34 beds per hospital--hardly enough to make an impact in this much needed program. The VA must recognize that the aging veteran will require increased acute care so, therefore, the conversion strategy must not be allowed to undermine the VA's acute-care capability. It is obvious, the current budget reflects OMB's directive to reduce actual major construction projects from five projects a year to two. At this rate, it appears the VA will have a very difficult time in providing modern facilities for their acute and long-term care responsibilities. The VFW believes it is essential to initiate an agressive modernization/renovation/replacement program inasmuch as 53 percent of VA's beds are housed in buildings over 30 years old.

The VFW applauds the proposed increase in outlays for medical and prosthetic research from about $181.5 million in fiscal year 1986 to approximately $187.3 million in fiscal year 1987. This represents an increase of about $5.8 million in an area in which the VA has long been regarded as a leader and for which there is no replacement in the private sector. VA medical and prosthetic research has brightened and improved the lives of those veterans to whom this nation owes its greatest debt--those who sacrificed their physical and mental and, yes, even spiritual well-being in the service of their country. Further, it must be remembered that in providing for these very special citizens, the VA has also improved the lot of each and every American. Unfortunately, within the area of medical programs, reductions in outlays are being proposed in medical administration, miscellaneous operating expenses, grants to the Republic of the Philippines, the Canteen Service Revolving Fund, and the Special Therapeutic and Rehabilitation Activities Fund. Once again, the VFW is alarmed that reductions are being proposed within the VA's medical programs at a time when the facts clearly argue for an increase.

Personnel reductions are not only going to be felt in medical care but also in the Department of Veterans Benefits. While DVB shows an overall increase of 400 personnel, regional offices will lose about 211 key support service personnel. This decrease is justified by the dubious claim they will not be needed because of modernizations in the delivery system. While we support this modernization effort, we only remind the Committee to look back to the 1970s when vast premature reductions of Regional Office personnel were carried out on the basis of the TARGET system which never fulfilled its promise. Actually, when the 400 personnel increase in DVB is closely scrutinized, this increase is for the most part only a paper transfer of computer operators from the old Office of Data Management and Telecommunications.

The proposed budget contains numerous legislative proposals, some of which will totally destroy proven, beneficial programs. One proposal calls for the redefining of the eligibility requirements for receiving a cemetery plot allowance. As you know, we opposed the elimination of the $300 burial allowance for those not in receipt of disability compensation and we certainly oppose the attempt to deny a similar benefit--the $150 plot allowance to this same group of veterans.

The President is also asking Congress to approve legislation affecting the VA Home Loan Guaranty Program by increasing the loan origination fee from the current one percent to two percent. This fee would gradually be increased to 3.8 percent by 1990. We believe this increase is totally unnecessary inasmuch as the revised estimated demand for a VA guaranteed loan will generate increased revenue from the current one-percent user's fee. I would like to point that an increase in the user's fee in all likelihood would prove counterproductive by decreasing the demand and therefore reducing revenue. If the user's fee is increased and restrictions are placed on the program as a result of Gramm-Rudman-Hollings such as capping loans at $90,000, many veterans will be unable to obtain home ownership.

Another initiative proposed by the Administration is the repeal of the new GI Bill. Mr. Chairman, the VFW does not understand how the Administration could even consider such a ridiculous proposal. In hearings held by the House Veterans' Affairs Committee just a few months ago, evidence and testimony clearly affirmed the program as a total success. Preliminary data have shown the new GI Bill as being directly responsible for dramatic gains in military recruitment and retention, allowing our nation to maintain and improve strength levels for both active duty and reserve forces while avoiding a return to the draft. The program's cost will be offset several times over by reductions in bonus pay and training costs. We believe it would be a tremendous mistake to have encouraged thousands of young recruits to join the military and obtain an education under this specific program, then suddenly deny them that opportunity. The United States Army in a document prepared in response to this budget decision stated the repeal of the new GI Bill will cause "widespread confusion and turbulence" and damage the recruiting program. The document also stated: "(The GI Bill) is a low cost, highly visible means for economically deprived youth to finance a higher education and fully achieve their potential...New soldiers in the Army are participating in the new GI Bill at rates dramatically higher than the previous education program."

Mr. Chairman, in closing, I want to take this opportunity to again reiterate our position. In almost its entirety, the President's proposed fiscal year 1987 budget for the Veterans Administration is unreasonable and unworkable. We urge you to remember the VA has a history of doing its fair share in attempting to reduce our nation's deficit. The VA has routinely tightened its belt to the point where it is now down to bare bones. Any more reductions will cause at best the deterioration or at worse the absolute elimination of basic benefits and entitlements. Let's not forget--veterans' benefits and entitlements are a direct cost of war; a truely strong nation is dependent upon those who served. Who have served and given up more than our nation's veterans?

Mr. Chairman, pertinent resolutions adopted by the voting delegates to our most recent National Convention are appended to my testimony and I will be happy to respond to questions you may have at this time. Thank you.

Resolution No. 617

STAFFING REDUCTIONS IN VETERANS ADMINISTRATION HOSPITAL SYSTEM

WHEREAS, the present administration proposes a reduction of 8,000 medical care personnel within the Veterans Administration's Department of Medicine and Surgery by 1990; and

WHEREAS, a reduction in health care personnel of this magnitude would seriously impair the Veterans Administration's capability to provide quality health care to the veteran; and

WHEREAS, the already targeted 1,900 personnel reduction under the one percent productivity improvement program proposed for 1986 in itself severely impedes VA medical care programs; and

WHEREAS, the Veterans Administration is already operating with a shortage of medical care personnel in excess of 12,000 with productivity at 115 percent. With a 1,900 personnel reduction, productivity would be raised to 117 percent; and

WHEREAS, no hospital in the private sector could ever operate at such a high level or productivity over such a period of time without seriously endangering patient care; now, therefore

BE IT RESOLVED, that the 86th National Convention of the Veterans of Foreign Wars of the United States, opposes further reductions of medical care personnel within the Department of Medicine and Surgery of the Veterans Administration.

Adopted by the 86th National Convention of the Veterans of Foreign Wars of the United States held in Dallas, Texas, August 16-23, 1985.

Resolution No. 617

Resolution No. 662

CONCERNING RECENT CHANGES IN POLICY BY THE DEPARTMENT OF MEDICINE AND SURGERY, VETERANS ADMINISTRATION

WHEREAS, Title 38, of the U.S. Code, Section 610 (A) authorizes the Administrator of the Veterans Administration to furnish hospital care or nursing home care for:

1) any veteran for a service-connected disability
2) nonservice-connected veterans who are unable to defray expenses for the care
3) former POW's
4) nonservice-connected veterans at age 65 or older; and

WHEREAS, such veterans are now in the process of being discharged from the Veterans Administration Medical Centers' Nursing Home Care Units because Congressional funding is not sufficient to cover this expense; and

WHEREAS, these veterans are faced with traumatic ramifications that will be caused by their transfers or discharges; and

WHEREAS, these veterans at the time of admittance to these facilities were verbally guaranteed lifetime care; now, therefore

BE IT RESOLVED, by the 86th National Convention of the Veterans of Foreign Wars of the United States, that we urge the Congress of the United States to fund the Veterans Administration Medical Centers for all of its needs to include nursing home care within the Medical Centers, to keep a promise to our veterans; and

BE IT FURTHER RESOLVED, when new policies or policy changes are to be made that affect the veterans in the Medical Centers of nursing care units by the Department of Medicine and Surgery, consideration should be given on a case by case basis with special consideration given to those who have spent a large portion of their adult life protected by such institutions, and the traumatic results on their being discharged or released to another agency; and

BE IT FURTHER RESOLVED, that the promises given to our veterans in good faith, and taken in good faith, be kept by the United States Government, because America is number one, thanks to its veterans.

Adopted by the 86th National Convention of the Veterans of Foreign Wars of the United States held in Dallas, Texas, August 16-23, 1985.

Resolution No. 662

Resolution No. 654

VA HOME LOAN GUARANTY PROGRAM

WHEREAS, the VFW views the VA Home Loan Guaranty Program as one of the most successful and beneficial programs available to veterans; and

WHEREAS, the popularity of this program is evidenced by the fact that over eleven million loans have been guaranteed to date; and

WHEREAS, recent adverse economic conditions have forced many veterans into foreclosure proceedings along with placing the solvency of the VA Loan Guaranty Revolving fund in jeopardy; and

WHEREAS, "user-fees" have been enacted and subsequently increased in an effort to remedy the ailing revolving fund; and

WHEREAS, various other proposals have emerged that would in all likelihood undermine the program and the Administrator 's ability to manage said program; and

WHEREAS, constructive changes in the VA Home Loan Program, such as granting the VA Administrator the authority to (a) independently set VA Home Loan rates; (b) exercise greater latitude in establishing the VA home loan guarantee percentage/ maximum amount; (c) authorize veterans the option to engage the service of buyer broker; and (d) amend the VA foreclosure policy so as to enhance the VA Loan Guaranty Revolving Fund, may strengthen that program; now, therefore

BE IT RESOLVED, by the 86th National Convention of the Veterans of Foreign Wars of the United States, that we seek the introduction and enactment of legislation that will serve to maintain the VA Home Loan Guaranty Program as the most viable and desirable means of home financing; and

BE IT FURTHER RESOLVED, that every effort be made to resist any adverse or discriminatory action which would undermine this valuable program or the veteran's ability to participate in it; and

BE IT FURTHER RESOLVED, that we adamantly oppose any effort to increase further the current user fee; and

BE IT FURTHER RESOLVED, that the Administrator of Veterans Affairs and other concerned parties be encouraged to actively assist veterans in maintaining their homes during economic crisis.

Adopted by the 86th National Convention of the Veterans of Foreign Wars of the United States held in Dallas, Texas, August 16-23, 1985.

Resolution No. 764

OPPOSE CUT-BACKS OF VETERANS BENEFITS

WHEREAS, it is noted that the federal government is still continuing to cut-back veterans benefits; and

WHEREAS, we recognize that veterans have given themselves in protection of this country and many are suffering from disabilities; physical, psychiatric and emotional; now, therefore

BE IT RESOLVED, by the 86th National Convention of the Veterans of Foreign Wars of the United States, that we oppose any cut-backs of veterans benefits and do everything possible to enhance veterans entitlements and benefits.

Adopted by the 86th National Convention of the Veterans of Foreign Wars of the United States held in Dallas, Texas, August 16-23, 1985.

STATEMENT OF
STEPHEN L. EDMISTON
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
FEBRUARY 20, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans and its Ladies Auxiliary, I am pleased to appear here today to discuss the budget request for the Veterans Administration for Fiscal Year 1987.

Let me begin by thanking you, Mr. Chairman, and the members of the Committee for soliciting our views on the Fiscal Year 1987 VA budget request prior to submitting your recommendations to the Senate Budget Committee.

Before specifically addressing the VA's proposed Fiscal Year 1987 budget request, Mr. Chairman, we believe that it is important to point out that the obvious driving force that has shaped this budget is the Gramm/Rudman/Hollings balanced budget amendment. Not only has Gramm/Rudman/Hollings influenced the make up of the Fiscal Year 1987 budget request, but it has also inflicted direct benefit reductions on deserving service-connected disabled veterans, their dependents and survivors in the current Fiscal Year.

Therefore, as the Committee considers the VA's Fiscal Year 1987 Budget Proposal, we urge you to fully consider taking appropriate actions to insure that VA programs and benefits that impact directly upon service-connected disabled veterans and their dependents are protected from the provisions of Gramm/Rudman/Hollings.

As you know, Mr. Chairman, on behalf of the Veterans Administration, the President is requesting $26.6 billion in budget authority to administer the various programs and services for millions of our nation's veterans and their families in Fiscal Year 1987.

In budget authority, the VA request is approximately $408 million below the Fiscal Year 1986 level, primarily due to so called "projected savings" that include:

- staffing reductions of more than 8,900 health care professionals;
- a substantial decrease in the number of veterans treated as inpatients and outpatients;
- substantial reduction in construction funds;
- an incremental increase from 1% to 3.8% in the user fee charged to VA guaranteed home loans;
- seeking no funding for the Veterans Job Training Program;
- repealing the VA's authority to grant education loans;
- closing the all volunteer force GI Bill to new enrollees;
- a change in eligibility criteria for the VA plot allowance.

Overall, Mr. Chairman, these projected savings, coupled with other budget proposals and the Gramm/Rudman/Hollings sequestering order to become effective March 1, 1986 will clearly jeopardize the VA's ability to provide continued quality care at every medical facility in the VA health care system.

Medical Care

The Fiscal Year 1987 budget request calls for an overall decrease in funding in the VA's medical care account of $46.1 million below the Fiscal Year 1986 level.

At first glance, Mr. Chairman, it would appear that the funding reduction for VA medical care is quite small, however, when you look beneath the surface and examine the budget documents for the VA's medical care funding proposal, you discern an entirely different picture.

For example, the VA proposes to:

- treat fewer "low priority" veterans;
- reduce medical care personnel by 1%; and
- nearly eliminate beneficiary travel.

By so doing, they would reduce the number of medical care personnel by more than 8,900 and save over $500 million.

Furthermore, the loss of more than 8,900 medical care personnel translates into the loss of more than 1,300 nurses and 500 doctors and dentists, as well as other health care personnel.

As a result, the VA will treat fewer (so called) "low priority" veterans by 62,000 inpatients and 1.2 million outpatient visits, and further reduce the overall number of VA hospital and nursing home operating beds by approximately 3,000 from the Fiscal Year 1986 budget level.

Mr. Chairman, the President's proposed Fiscal Year 1987 VA budget request blatantly ignores the provisions of Section 5010(a)(1), Title 38, USC -- "The President shall include in the budget transmitted to the Congress for each fiscal year pursuant to section 1105 of title 31, an amount for medical care and amounts for construction sufficient to enable the Veterans' Administration to operate and maintain a total of not less than 90,000 hospital and nursing home beds in accordance with this paragraph ..." (emphasis added)

The budget documents reveal that during Fiscal Year 1986 the VA will operate at least 900 beds below the statutory requirements and will seek to further circumvent the law by operating 4,000 fewer beds than the law requires in Fiscal Year 1987 ... and at the same time they propose to cancel all new VA nursing home construction.

We must question, Mr. Chairman, why the VA (or OMB) is seeking such drastic reductions in VA medical care funding when their own statistics reveal they are turning away more than 30,000 eligible veterans who are seeking VA health care services each month.

In the past OMB has made it perfectly clear that they would like "to shrink the size of the system" -- but is this their real effort or do they want to simply destroy the VA health care system?

As you know, Mr. Chairman, the VA health care system has been on a serious decline for a number of years due to negative (deflated) funding. The proposed Fiscal Year 1987 medical care budget request only exacerbates this chronic state that has existed for more than a decade.

Reduced medical care funding, coupled with such proposals as drastic reductions in health care personnel, decreasing the number of veterans treated, elimination of most beneficiary travel funds, reducing the number of available operating beds and providing no new funding for the Health Professional Scholarship Program, only serve to jeopardize the quality of health care provided at each and every VA medical facility.

We note, Mr. Chairman, that the VA is again proposing legislation to (1) repeal section 610(a), Title 38, USC -- providing eligibility for hospital or nursing home care for a nonservice-connected disability if the veteran is 65 years of age or older -- (2) establishing a means test for certain categories of veterans without service-connected disabilities and (3) provide authority for the VA to collect reimbursements from private health insurers of nonservice-connected veterans receiving VA health care services.

These legislative proposals, as you know, Mr. Chairman, were addressed by this Committee and your counterpart in the House and are currently pending in the Omnibus Budget Reconciliation Act of 1985 -- H.R. 3218.

For the record, Mr. Chairman, the DAV remains opposed to the Administrations' proposed means test. However, the DAV supports the medical care eligibility changes agreed to in H.R. 3218. These provisions, in our view, are a significant step to strengthen and enhance health care for all service-connected disabled veterans.

With respect to the proposal to authorize the VA to collect reimbursements from private health insurers -- as proposed by the VA and contained in H.R. 3218 -- the DAV remains unconvinced the VA will in fact receive revenue in excess of the administrative costs of implementing and collecting these payments.

Mr. Chairman, we encourage you, and the members of the Committee, to carefully scrutinize the Fiscal Year 1987 funding levels proposed for the VA medical care program. We believe such scrutiny will lead you to recommend to the Senate Budget Committee realistic levels of funding (unlike that proposed by the President) that will acknowledge the importance of providing timely, quality medical care services to the nation's eligible veterans.

Construction

The VA's Fiscal Year 1987 construction request is $465 million, some $332 million below the $797 million Fiscal Year 1986 level.

Mr. Chairman, while we support full funding of the VA's request for construction programs we are, quite frankly, seriously concerned that this type of construction request fails to adequately address the needs of the aging capital plan of the VA health care system.

Furthermore, while more and more elderly veterans are seeking nursing home care from the VA, this construction request reflects a new OMB mandated policy which directs the VA to shift the responsibility for VA nursing home care to state and community nursing facilities. As a result all new VA nursing home projects have been cancelled.

The VA's Fiscal Year 1987 budget request does contain, however, a $21.5 million increase (over the Fiscal Year 1986 level) in grants for construction of state extended care facilities. The VA's request of $42.4 million will provide for an additional 120 nursing home care beds, 126 convertible domiciliary/nursing home beds and 150 domiciliary beds.

As you know, Mr. Chairman, this particular federal/state sharing program has been a tremendous success in terms of encouraging states to actively participate in the nation's commitment to providing quality care to her eligible veterans. However, the DAV does not believe the federal government should relinquish its primarily responsibility for veterans health care -- especially in the nursing home care area.

Additionally, we have noted that the VA continues to reduce the number of medical, surgical and psychiatric beds, while at the same time providing modest increases in the number of intermediate and nursing home care beds, to include conversion of some existing hospital beds to nursing home care beds.

While the DAV does not object to some realignment of operating beds we trust an appropriate balance will be maintained to meet the acute, intermediate and long term health care needs of all eligible veterans

Mr. Chairman, the VA construction request for Fiscal Year 1987 simply does not go far enough to allow the VA to accomplish what must be done if the health care system capital plant -- which represents a multi-billion dollar investment on the part of the American taxpayer -- is to remain viable.

Proposed Legislation

The Administration's Fiscal Year 1987 budget request proposes legislation, in addition to that which I have previously discussed, that would provide for (1) an increase of 3.7% in the rates of Disability Compensation and Dependency and Indemnity Compensation (DIC) effective December 1, 1986; (2) increasing the loan origination fee incrementally from 1% to 3.8% by 1990; (3) changing eligibility for the plot allowance so that it would be the same as the burial allowance; (4) repealing the VA's authority to make education loans; and (5) closing the All Volunteer Force GI Bill to new enrollees and reopen the Post Vietnam Era Education Program.

The DAV is pleased with the Administration's proposed cost of living adjustment in the rates of Disability Compensation and DIC benefits -- in recognition of the special consideration service-connected disabled veterans and their survivors should be given.

Accordingly, Mr. Chairman, the DAV supports the enactment of legislation that would provide disability compensation and DIC recipients with a cost of living adjustment in line with the rise in the Consumer Price Index effective December 1, 1986.

As noted, the Administration has again proposed increasing the home loan guarantee program users' fee incrementally from 1% to 3.8% by 1990.

We believe the Committee should carefully evaluate the adverse impact this proposal will have on Vietnam veterans, who are the primary beneficiaries of the program today and, should it be rejected, we respectfully request that the Department of Veterans Benefits be exempted from absorbing the funds associated with the proposed legislation.

However, as a result of the sequestering actions of Gramm/Rudman/Hollings that directly impact on the VA home loan program, and are scheduled to take effect on March 1, 1986, it would appear the entire home loan program is doomed for the remainder of Fiscal Year 1986 ... unless Congress takes action to relieve the problem.

Veterans Employment Programs

Mr, Chairman, we have also reviewed the proposed budget for veterans' employment and training programs administered through the Office of the Assistant Secretary of Labor for Veterans Employment and Training.

Before proceeding, however, I wish to express our disappointment with the Veteran Administration's failure to request funding for the Veterans Job Training Act for Fiscal Year 1987. The reasons cited by the VA for not requesting additional funds -- (1) a significant drop in unemployment of Korean conflict and Vietnam era veterans and (2) the program unnecessarily augments job services for veterans by the VA and other government agencies -- reiterates, in our view, the Administration's continued lack of support for this important employment program for veterans.

With respect to the Office of Assistant Secretary of Labor for Veterans' Employment and Training, the Administration has proposed a Fiscal Year 1987 budget request of $ 13.1 million. This amount will fund 279 positions -- a reduction of 3 from the current Fiscal Year authorized level of 282.

As you know, the Office of Assistant Secretary of Labor for Veterans' Employment and Training also has responsibility for distributing the funding for Disabled Veterans Outreach Program (DVOP) and the Local Veterans Employment Representative (LVER) program.

In this regard, the Fiscal Year 1987 budget proposes $69.4 million to support 1,894 DVOP positions. The LVER program, on the other hand, is slated for a reduction of more than $6 million from the Fiscal Year 1986 level. The Fiscal Year 1987 LVER budget request of $48.9 million will result in the loss of more than 200 full-time equivalent positions and, in our view, will definitely impact adversely on services provided to veterans.

Mr. Chairman, we are concerned that continued employment services to veterans may be reduced due to the overall decline in personnel system wide. In this regard we urge the Committee to continue its support for full funding of the DVOP and LVER programs.

Conclusion

In closing, Mr. Chairman, in addition to the views we have already set forth with respect to the VA's proposed Fiscal Year 1987 budget request, I want to further emphasize and underscore our very serious concern for the VA health care system and the devastating effect this budget (if approved as proposed) spells for those eligible veterans who rely on the system for medical care.

We urge the Committee to favorably recommend to the Senate Budget Committee levels of funding that realistically and adequately address the needs of all programs administered by the VA.

Again, Mr. Chairmain, I wish to thank you and the members of the Committee for providing us this opportunity to express our view on this most important subject.

PVA

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
R. JACK POWELL, EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING THE
PROPOSED FISCAL YEAR 1987 VETERANS ADMINISTRATION BUDGET
FEBRUARY 20, 1986

Mr. Chairman and Members of the Committee, I am R. Jack Powell, Executive Director of Paralyzed Veterans of America, and I want to thank you for affording me the opportunity to appear here today.

PVA appreciates the Committee holding this hearing, and for being able to express our views and concerns regarding this most important issue, the Administration's proposed Fiscal Year 1987 Veterans Administration Budget.

As you know, all of PVA's members are veterans who have experienced spinal cord injury or dysfunction, and it is on behalf of these veterans who have considerable contact with the VA's Regional Offices and Medical Centers located throughout the United States that we present our views today.

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300

Mr. Chairman, the budget proposed for the Veterans Administration for Fiscal Year 1987 is, without a doubt, the most deplorable attack on veterans and the programs and benefits which have been established to meet their needs. In past years we have found shortcomings in proposed VA budgets, but never have we seen such a blatant abdication of the nation's responsibility to the men and women who have rendered service. This budget proposal is more than an effort to curtail federal spending and reduce the deficit, it is an overt effort to eliminate veterans' benefits and preclude veterans' access to needed services, particularly in the the area of medical care.

The proposed budget purports to be a reduction of $408 million below the current year, including $234 million sequestered under the provisions of the "Balanced Budget and Emergency Deficit Control Act of 1985." However, upon examination of the proposals contained within the Fiscal Year 1987 VA budget, it becomes obvious that benefits and services for veterans will be reduced in excess of $1 billion. The budget proposal assumes the Veterans Administration will absorb the effects of inflation, the additional costs associated with cost-of-living increases in compensation, dependency and indemnity compensation (DIC), and pension, and salary increases for employees. All of these factors will drastically diminish the VA's capability to meet the requirements for adequately providing for veterans.

Over the past several years we have observed that budgets for the Veterans Administration were basically current services proposals, providing for no real growth in benefits and services. This year's budget proposal falls significantly below any such description and can be viewed only as an effort by this Administration to reduce the scope and availability of services and benefits for veterans. The Fiscal Year 1987 budget proposal for the Veterans Administration falls far short of meeting the current needs of veterans and fails miserably to adequately address future needs.

PVA recognizes the need to reduce the federal deficit, but in examining the proposed Fiscal Year 1987 VA Budget, we find the targeting of veterans' health care and services as a source of spending cuts and deficit reduction to be a reprehensible approach and disservice to the men and women who have served the nation.

Historically, this country has cared for its veterans. This huge task cannot be left to state and local governments which are not equipped for such an effort, and are already overburdened. The cost for providing for our nation's veterans is an obligation that is associated with the continuing cost of our national defense.

Mr. Chairman, this year, the nation's 28 million veterans, and their 54 million dependents and survivors will have to rely more than ever upon the wisdom and energies of this Committee, and Congress as a whole, to secure adequate funding for the programs and services administered by the VA. Repeatedly, Congress has had to struggle to add funding to proposed VA budgets that were patently insufficient to meet the needs of the nation's veterans, and the task this year will certainly be as challenging as any we have witnessed during the past several years.

The Federal budget that is submitted to Congress each year defines our nation's values and establishes the President's priorities. The nearly $1 trillion budget proposed for Fiscal Year 1987 represents a retreat from our commonly held values, disregards this nation's and Congress' approach for dealing with the deficit and certainly misplaces priorities. If the budget that was submitted to Congress were enacted, as proposed, more that $20 billion in additional reductions would be cut from already curtailed domestic programs that this administration has continually cut since 1981. At the same time, under the banner of national security, military spending would increase 8 percent, by more that $34 billion in budget authority.

We all share a concern and a commitment to national security, but simply throwing more and more money at the Defense Department is not necessarily going to provide Americans with the defense they expect. The scandalous abuses of military spending that have been uncovered in the past two years clearly demonstrate the inability of the defense community to exercise any efficiencies in effectively administering these increased levels of budgetary authority. Yet, to finance this relentless build up, the American people are asked to accept greater sacrifices and absorb deeper cuts in domestic programs.

The operating budget proposed for Fiscal Year 1987 for the Veterans Administration is just one example of the many programs that have been offered up as sacrificial fodder. As former members of this nation's military service, veterans cannot and will not tolerate the continued reduction in benefits and services which this grateful nation obligated itself to provide us. This obligation was not made under duress. It was not conceived as a great social program, it was provided out of appreciation for the service, the sacrifice and in many cases, for the personal injuries that we, as citizen soldiers incurred in defense of our nation's ideals. Now, under the guise of fiscal constraint, we veterans are supposed to be content with less than that which was promised. We are to forget our fellow serviceman, those who did not hesitate to give their full measure when asked to fight.

The federal deficit problem is of concern to each and every American, veterans included, but the astronomical deficits that have accumulated over the past five years of the Reagan presidency are not of our doing and we are not willing to allow you or the Administration to forget the obligations and responsibilities incurred by previously enacted legislation benefiting veterans, their families, and their survivors.

The Veterans Benefits and Services function of the federal government, as administered by the Veterans Administration, has increased by approximately 25 percent since 1980, with outlays rising form $21.2 billion to $26.4 billion in the 1987 budget request (House Budget Committee statistics). On the surface this amount may seem adequate, and compared to other nondefense related programs, veterans certainly have not fared as badly as most. Still, one must remember the more than fifty-year mission of the VA, that being "to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support and recognition earned in service to this nation."

This they have attempted to do over the years, but recently veterans and certainly you, as members of Congress must be wondering if the role of the VA has not been usurped by a small band of pencil pushing, number crunching, administration surrogates housed in the Office of Management and Budget, who without concern, save for spending a buck, coldly and dispassionately cut this program and that.

Medical Care

Mr. Chairman and Members of the Committee, the most devastating single component of the Fiscal Year 1987 VA budget proposal is in the area of health care. No VA service provided to veterans is more critical or important to their well-being, and in many cases, their very survival, than health care. The callous proposal in the budget to reduce inpatient episodes of care by 57,354 and outpatient episodes of care by a staggering 1, 114,000 is beyond comprehension. Such a proposal highlights a total disregard for the nation's commitment to veterans.

The reductions in the number of inpatient and outpatient episodes is to be achieved by treating fewer "low priority veterans." The budget fails to define or identify who these veterans are and it assumes that the denial of care to these veterans will not be offset by the demand for care currently being denied some 30,000 plus veterans each month. This effort is clearly an attempt to constrict the VA health-care system and allow dollars, not need, to shape the scope and operations of VA medical care.

The VA requested $10.041 billion to provide veterans VA medical care. Despite this request, the Administration and OMB allowed only $9.083 billion for this important veteran benefit, and in so doing failed to provide monies for the thousands of veterans who are being turned away from VA health-care facilities each month. They failed to provide for the expansion of the GRECC's (Geriatric Research Education and Clinical Centers) as mandated by P.L. 99-166, and they apparently shifted responsibility for dealing with the aging veteran population onto the states in that medical care provided in non-VA facilities is the only subaggregate of the medical care account that would receive any new monies.

The budget proposal notes that the funding levels requested will provide for the maintenance and operation of all existing VA health-care facilities. While physical structures may remain, services certainly will be diminished. The budget proposal which calls for the loss of over 7,500 FTEE's in medical care, including 1303 nurses and 475 physicians, assumes only a reduction in quantity of services provided. PVA contends that quality will also be reduced with the elimination of such a significant number of FTEEs involved in direct medical care.

Without these medical care personnel the VA is going to be very hard pressed to address the specific and emerging special program areas of: services to aging veterans; female veterans; Vietnam veterans; veterans exposed to Agent Orange and Ionizing Radiation; former Prisoners of War; and of particular concern to us, certain VAMCs may not be able to provide the highly specialized care and rehabilitative service to those veterans who are paralyzed due to spinal cord injury or disease. We have testified on numerous occasions that the VA system of 20 medical centers that specialize in spinal cord injury are unparalleled in this nation for their combined expertise and concern. It is incumbent to maintain the VA medical care account at a funding level that most adequately serves the needs of all veterans, both now and in the future.

In regards to the number of veterans eligible for VA health-care services, the VA estimates that under existing legislation, 11,984,000 could, if they so desired, qualify for care. Of this population pool, only about three million veterans availed themselves of VA medical care in 1984. Last year the Administration proposed legislation to implement a "means test" for health care eligibility. That proposal was very inequitable but a more realistic "means test," disconcerting as the concept is, was finally ironed our and agreed to by the Committees on Veterans' Affairs, Mr. Chairman, only to be denied realization because of a reconciliation stalemate over Superfund.

Hopefully, Mr. Chairman, the earlier adopted version of a "means test" can be pulled from existing legislation and enacted in lieu of the Administration's test. Our concern for implementation of an equitable "means test" stems from the VA's Fiscal Year 1987 projected budget savings of more than $350 million and 6,988 FTEEs that purportedly will be realized by treating fewer "low priority veterans." We not only challenge the legitimacy of this cost savings, we fail to believe that the integrity of the VA health-care system can be maintained with such cuts in personnel and changes in patient mix.

In addition, we challenge the VA's or OMB's assumption that another 1,939 FTEEs and $57,200,00 can be realized through increased productivity in the medical care account during Fiscal Year 1987. We do not mean to imply there are not operations which cannot be improved or FTEEs who cannot be more effectively utilized, far from it, but it is high time that this Administration realize what an efficient health-care delivery system it has operating within the Veterans Administration. According to the figures contained within the House Budget Committee's analysis of the 1987 budget, VA hospital and medical care costs have only risen approximately 50 percent, while demand has increased since 1980. This indicates a cost-effective system compared to the private sector where the cost of a hospital room alone has increased by 63.2 percent and doctor fees have increased 46.3 percent over the same time frame, according to figures recently released by the Bureau of Labor Statistics.

VA Medical and Prosthetic Research

Another area of the VA budget with which we are very much concerned lies in the area of medical and prosthetic research. The $226,634,000 that was expended in Fiscal Year 1985 for this vital investment in the future care and rehabilitation of severely disabled veterans represents less than 1/10th of one percent of the total VA budget; yet, this account took a nearly 18 percent or a $40 million cut in Fiscal Year 1986 budget considerations. Now, seven months into Fiscal Year 1986, the President proposes to restore the $7,885,000 lost to sequestration back into this account in the coming year, but the research will be performed by 285 fewer FTEEs than were available last October. We view this unstable fluctuation of both funding and staffing as a devastating approach to maintaining the integrity of the VA's highly sophisticated, highly client-oriented research programs.

Granted, as has been the case over many, many years, when monetary funds become scarce, research activities, especially those that do not hold promise of an immediate return on investment, are curtailed or in some cases terminated. We are very concerned that the VA's research efforts into central nervous system disorders such as spinal cord injury, disease, and regeneration will be seriously disrupted. Such vacillation of commitment toward the one ray of hope and cure for the insidious ramifications of the many, as yet, unexplained medical phenomenons, we view as being penny-wise and pound-foolish. The VA's list of "Who's Who" in medical and prosthetic research is extensive as well as impressive, and the benefits that are and can be realized by their combined expertise should not be taken lightly. We request that additional monies be channeled into this important portion of the VA's Fiscal Year 1987 budget, especially as it pertains to the VA's targeted high priority research which includes spinal cord injury and tissue regeneration.

Personnel

Another aspect of the proposed Fiscal Year 1987 budget that is of concern to PVA lies in the VA Central Office's approach to maintaining critical manpower needs. We must question the rationale for all the reorganization proposals that have been submitted. We feel, this year, more so than in years past that the Veterans Administration has given up in their fight to advocate for the real needs of veterans and has instead decided that its new mission should be to maintain itself, meaning those bureaucratic functions that best serve that Administration, rather those that best serve the veteran population. This is harsh criticism to levy at the one agency within the federal government that is charged with the mandate of providing for veterans, and maybe after all the continuous assaults by this Administration to pare down the size of the federal government and shift more and more functions and responsibility to the state and local segments of our society, the VACO has assumed a "bunker mentality" and is engaged in a new mission of protecting its own employees at the cost of providing veteran services.

A prime example of this reprogramming of missions lies in its formation of the new Office of Facilities. When the budget proposes such drastic cuts in overall VA construction, it is difficult to understand why 733 FTEEs are needed to supervise a reduced function, whereas, without hard data to support the reduced need for hospital medical personnel, namely 1,303 nurses and 475 doctors, they choose to let these people go. We have been informed that certain of the nearly 7,500 FTEEs scheduled for termination in the medical care account are to be absorbed into this new Office of Facilities. This is good for those affected employees, but how will this reprogramming aid in service to veterans?

Another example of VACO entrenchment was their handling of the "sequestration order" that was recently issued by the President. In this situation the VA opted to reduce the amount of monies available for specially adapted housing, auto grants and adaptive equipment, all direct benefits to veterans, rather than lay off personnel within that line-item function that could result in a comparable cost saving. Again, the question must be asked -- has the VA given up its role as chief advocate for veterans and is it now more concerned in trying to maintain the status quo among its own bureaucratic rank and file?

Another directive that has surfaced, not contained within the actual Fiscal Year 1987 VA budget per se, but contained in OMB documents relating to the VA's 1987 passback, was the mention made of restricting VA health care to nonservice-connected veterans to a maximum of 500,000 episodes in Fiscal Year 1987. The OMB directive to the VA indicated that it would approve funding for 1,243,700 inpatient episodes of veteran care, and limit nonservice-connected veterans to 500,000 episodes. PVA finds this directive not only unrealistic, but totally immoral, unprincipled and possibly in violation of congressional intent. The concept of establishing health-care usage ceilings might be an acceptable planning practice in the sterile, compassionless setting of the OMB office; but, when the VA's own data reveal demographic and patient profiles that support a totally different patient mix, then we are left to assume that OMB is in an outright assault on the VA's ability to perform its mission.

VA Construction

PVA believes the VA's Fiscal Year 1987 proposed construction budget of $408 million in new budget authority, a reduction of over $208 million from 1986, clearly demonstrates that the Administration is continuing not to recognize (or to ignore) the importance of maintaining and building adequate facilities if the VA is to perform its assigned function.

Equally disturbing, or puzzling, is that while the VA's office of construction 1987 budget will be reduced by 34 percent from the previous year, and coupled with certain duties being taken over by another department, the construction employment level will increase by 49 FTEEs.

A newly constituted associate deputy administrator for management will now perform construction's independent facilities management and will be funded with 10 new FTEEs. In addition to all of this, an office of facilities, another brand new office created under reorganization, is requesting a funding level of $38.9 million and 733 FTEEs for 1987. It is hard to understand the Administration's or VA's rationale for the significant increase in FTEEs within construction and facilities management, when little or none is taking place.

The needs of the aging veteran population will continue to place an ever growing demand on the VA's health-care delivery system, escalating an already critical situation. It is a very serious matter that so many VA facilities are now in a state of decay, only marginally meeting the needs of the veterans who use them. In previous years, testimonies given by veterans' service organizations and the Department of Medicine and Surgery indicated that over half of all the beds located in VA facilities are in buildings 35 years old or older. Decaying facilities not only diminish efficient patient usage, they also hamper the recruitment and retention of qualified doctors and nurses.

The coming impact of the aging veteran had been a responsibility which the Veterans Administration was taking seriously. Now the VA has determined to shift its mission, by restructuring its long-term care policy, relying on the states and their communities to furnish the necessary facilities for providing care.

While the proposed Fiscal Year 1987 funding for grants for construction of state extended care facilities provides an increase of over 100 percent from the current year, the funding for the construction of VA nursing homes has been reduced by 82 percent.

The VA funding to assist the states in the acquisition or construction of state nursing homes or the remodeling, modification, or alteration of existing state veterans' homes has increased to $42.4 million in 1987, up over $21.6 million from the previous year level of $20.8 million. This drastic increase in funding is somewhat unrealistic when keeping in mind the necessary planning, and restrictions that states must adhere to, not to mention the necessary funding they must secure, before such a facility can be obtained or constructed. It is apparent that more and more of the solutions to problems are being shifted to the states from the federal government. This is just one more situation evident today where the federal government is relying on the states, which are already overtaxed and overburdened, to assist in solving a critical shortage in providing for our nation's aging veterans. A task that is not rightfully theirs.

Veterans' Benefits

Mr. Chairman, the area of readjustment benefits is an issue of concern to PVA as proposed in the Fiscal Year 1987 VA budget. The Administration proposes to eliminate or significantly curtail numerous programs and services for veterans regardless of their obvious benefit and need. The new G.I. bill has already proven itself as a viable educational asset for veterans. The exceptionally high participation rate has significantly been of value to the military and, more importantly, will have long lasting benefits for individual veterans and the nation as a whole.

The failure to provide funding for the "Emergency Veterans' Job Training Act of 1983" is equally disconcerting. While unemployment may have decreased for certain segments of society, for those veterans without jobs, the need for this program still exists. There remain thousands of unemployed, eligible veterans who have been certified for training under this program, but who have not entered actual training. To eliminate funding when the economy's recovery offers these veterans their greatest opportunity seems to be inappropriate and counterproductive.

Another issue of concern to PVA's members is the Administration's attempt, within the proposed 1987 budget, to dismantle the VA's Home Loan Guaranty Program. Again, legislation is being considered this year, raising the current "users fee" from 1 to 2 percent, eventually rising to 3.8 percent by 1990.

The VA's Home Loan Guaranty Program is an entitlement program, with every veteran meeting the requirements being eligible for a guaranty of their mortgage up to 60 percent of the loan or $27,500, whichever is less.

PVA believes than an increase in the "user's fee", if enacted, would have a serious detrimental effect on the ability of veterans to obtain guaranteed loans, and thereby discourage veteran's home ownership. By raising the origination fee, veterans using their guaranty entitlement would either have to pay the increased fee up front, or have the fee added on to the loan.

This would result in a veteran needing a substantial amount of cash on hand, or add the users fee into the loan, thereby increasing the amount of the mortgage and exceeding the actual property value.

Equally disturbing within the VA's Home Loan Guaranty Program is the VA's plan to reduce the maximum guarantee by over $45,000, and to discontinue refinancing, while at the same time home prices continue to rise, both as a result of Gramm-Rudman.

Without a doubt, the VA Home Loan Guaranty Program, having assisted over 11 million veterans in obtaining suitable, affordable housing, has been one of the most successful in this nation's history. This program has been a good investment in America, providing stability and expanding the tax base of nearly every community in our country.

Mr. Chairman, the Fiscal Year 1987 budget proposal does provide for a cost-of-living increase in compensation, dependency and indemnity compensation and pension. This is one positive aspect of an otherwise bleak budget proposal. These cost-of-living increases will ensure that veterans and their survivors will not see their quality of life eroded by the effects of inflation. However, these proposed increases are achieved through the reduction of other benefits and services provided by the Veterans Administration.

Finally, PVA would be remiss if we did not address the VA's recent approach to achieving savings mandated through sequestration. Effective March 1, 1986, there will be a reduction in readjustment benefits paid to those veterans who are the more severely disabled, service-connected veterans. Vocational rehabilitation subsistence allowance, paid to those service-connected veterans who are in training, is cut over 13 percent. The grant for specially adapted housing, payable only to those veterans who are permanently and totally disabled is cut $2840. The grant to a service-connected veteran for the purchase of an automobile or other conveyance and/or to adapt one with necessary special equipment is cut $400.

This approach is abhorrent and reflects the insensitivity to and callous disregard for the service rendered by these eligible veterans. The VA demonstrated a willingness to reduce benefits for the most seriously disabled service-connected veterans rather than explore other methods for achieving the same savings.

This recent effort and the Fiscal Year 1987 budget proposal seriously call into question the esteem and regard which this Administration affords the nation's veterans and their past service. Hopefully, this Committee and the Congress will, as they have in the past, continue to honor and uphold the nation's obligation.

Mr. Chairman, that concludes my statement. Thank you and the Members of the Committee for your thoughtful consideration of this issue, and I will answer any questions that I can.

WRITTEN QUESTIONS FROM CHAIRMAN MURKOWSKI TO THE DEPARTMENT OF LABOR AND THE RESPONSES

QUESTION 1(a)

1. How will the Veterans' Employment and Training Service (VETS) be affected by the fiscal year 1986 sequester order?

(a) What will be the effect on the staffing and mission of the Veterans' Employment and Training Service?

ANSWER 1(a)

The agency will achieve its required spending reduction of $559,000 principally by not filling vacant positions, and not hiring youths and college students as it has in the past under Departmental summer employment programs. The OASVET foresaw the passage of the Gramm-Rudman legislation and began this effort to keep hiring below planned levels prior to the start of FY 1986, thereby creating a "cushion" that hopefully will obviate the need for involuntary separations of staff or furloughs without pay.

The agency will also reduce travel expenditures by 11% by holding funds in abeyance until the 4th Quarter to further reduce the need for imposing furloughs. Activities associated with those travel funds, such as training conferences, technical assistance visits to service providers, and employer visits, will be postponed until it is clear that the funds may be expended without causing need for furloughs.

The effects of these savings initiatives on the mission of the agency are difficult to forecast, as the activities affected for the most part are of presumed but generally immeasurable benefit to unemployed veterans.

QUESTION 1(b)

What will be the impact on the number of Disabled Veterans Outreach Program (DVOP) and Local Veterans' Employment Representatives (LVER's)?

ANSWER 1(b)

The Sequester Order (GRH) reduces our DVOP/LVER budget by $5,159,000 from $119,976,000 to $114,817,000.

The DVOP/LVER staffing levels for the first two quarters of FY 1986 were based on the funding available in the President's budget request ($111,486,000). The revised 1986 appropriation which included the sequestered dollars is $114,817,000. The increase is due to the supplemental of $8.4 million appropriated by the Congress. With this increased level for the last 2 quarters of the fiscal year, States will be able to maintain the required DVOP and LVER staff levels. The required levels call for 1,894 DVOP and 1,379 LVER staff.

QUESTION 2

Will the number of DVOP's and LVER's still comply with the staffing levels established by Title 38 after the FY 1986 sequester order is implemented?

ANSWER 2

Title 38 requires one DVOP specialist for every 5,300 Vietnam-era and disabled veteran residing in each State. The regulations at 20 CFR 652.123 require one full-time LVER be assigned to each local Job Service office receiving 1,000 new or renewal veteran applications in a 12-month period, unless waived by the Secretary for a demonstrated lack of need.

For FY 1986 the required formulas levels are 1,894 in the DVOP, and 1,379 in the LVER program. These levels will be maintained for the last 2 quarters of FY 1986, April 1, 1986 - September 30, 1986.

QUESTION 3

Is the number of DVOP's and LVER's set by fiscal year 1987 funding constraints or by the workload?

ANSWER 3

The FY 1987 budget request of $118,397,000 will not fund the number of positions required by the LVER formula set forth in 20 CFR 652.123. Since the DVOP formula is statutory and the LVER formula is an administrative requirement, the decision was made to address the legislated requirements first (DVOP) and meet the administrative requirements with the remaining funds (LVER).

QUESTION 4

The fiscal year 1987 budget request calls for increased funding of JTPA Title IV-C, targeted at recently discharged, disabled or Vietnam-era veterans.

(a) How much additional funding are you asking for this program?

ANSWER 4(a)

The budget request for fiscal year 1987 is $10,494,000. This is a $1,819,000 increase over the fiscal year 1986 level of $8,675,000.

QUESTION 4(b)

(b) How will you utilize the additional funds?

ANSWER 4(b)

Eighty percent of the funds will be allocated by formula to the States based on target group veterans population. The funds will be awarded to eligible applicants (which are States and local government agencies in service delivery areas) via a competitive grant process.

Twenty percent of the funds would be held in the Assistant Secretary's discretionary fund for projects with national implications, such as special programs for blinded veterans.

QUESTION 4(c)

(c) Will these funds be distributed to the states or held in the "20%" discretionary fund?

ANSWER 4(c)

The JTPA Title IV-C regulations require that at least 80% of the funds be made available to the States through the competitive process mentioned above. In fiscal year 1986, 89% of the funds were distributed in this fashion.

QUESTION 4(d)

(d) Would these funds, if appropriated, be vulnerable to reprogramming within the Department of Labor?

ANSWER 4(d)

No, we do not anticipate any reprogramming of these funds.

QUESTION 5

Gramm-Rudman requires an across-the-board 4.3 percent reduction in all non-deferral programs, except certain exempted programs. Are any programs exempt in DOL? If so, which?

ANSWER 5

The programs which are exempt in DOL are as follows:

Regular unemployment benefits

Black lung compensation payments

Federal disability payments

QUESTION 6(a)

Is the 4.3 percent cut being taken across-the-board in DOL?

ANSWER 6(a)

Yes, except for the programs mentioned above.

QUESTION 6(b)

Are certain services like VETS taking a smaller percentage cut than 4.3 percent?

ANSWER 6(b)

Each activity within the Department is taking the 4.3 reduction.

QUESTION 6(c)

If so, which other programs have to absorb the savings not being required in VETS? Who determined the percentage by which each service would be reduced?

ANSWER 6(c)

The percentage reduction was determined by OMB, GAO and CBO jointly.

QUESTION 6(d)

I would like, for the record, a Solicitor's decision regarding the legality of reprogramming savings requirements from one service to another?

ANSWER 6(d)

(Note: The Department of Labor subsequently supplied the following information pertinent to the requested information.)

U.S. Department of Labor

Assistant Secretary for
Veterans' Employment and Training
Washington, D.C. 20210

March 10, 1986

The Honorable Frank H. Murkowski
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Chairman Murkowski:

This is in response to a verbal request from a member of your staff asking for a clarifying statement regarding our response to your question on "the legality of reprogramming savings requirements from one service to another."

As previously stated, it is the Department's position that Gramm-Rudman required an across-the-board 4.3 percent reduction in all non-deferral programs, unless exempted. Accordingly, the Secretary directed an across-the-board reduction by 4.3 percent in accordance with the law. We do not foresee the necessity to request authority to reprogram funds from one program to another.

I hope this clarifies my previous response to this question.

Sincerely,

DONALD E. SHASTEEN

U.S. Department of Labor

Office of the Assistant Secretary
for Administration and Management
Washington, D.C. 20210

Reply to the Attention of:

27

MEMORANDUM FOR: DONALD E. SHASTEEN

FROM: MARY ANN WYRSCH Mary Ann Wyrsch
Director, Office of Budget

SUBJECT: Clarification of the treatment of budget reductions pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985

Questions raised to your office by the Senate Veterans' Affairs Committee about the procedures and implementation of budget reductions pursuant to P.L. 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 - otherwise known as Gramm-Rudman-Hollings (G-R-H) seem to pertain to actual experience in FY 1986 as well as possible implications for FY 1987.

Subsequent to receiving your memorandum of March 24, 1986 concerning the G-R-H inquiry, I and my staff met with Jeff Crandall in order to clearly establish the nature of the question(s) posed by the Senate Veterans' Affairs Committee. Apparently, the two issues involved concern: (1) the method of determination of how to apply sequestered amounts, and (2) opportunities for reprogramming remaining funds in order to prioritize programs.

Sequestrations or budget authority withheld by Presidental order in FY 1986 were applied across-the-board by reducing every program, project, and activity (PPA), by 4.3 percent. The definition of PPA was provided in the Conference Report (House Report 99-450) accompanying the FY 1986 full year Continuing Resolution (P.L. 99-190). Defined within this language, the term PPA includes the most specific level of budget items identified in:

-- Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act 1986 (P.L. 99-178)

-- The House Appropriations Committee Report (House Report 99-289)

-- The Senate Appropriations Committee Report (Senate Report 99-151)

-- The Conference Report (H.R. 99-402)

-- The "All Purpose" Table (Pages H-10915 through H-10940 of the Congressional record of December 5, 1985).

According to this definition, the PPA structure for Veterans' Employment and Training programs is as follows:

-- Disabled Veterans' Outreach Program

-- Local Veterans' Employment Representatives

-- Administration (Federal)

The factor, 4.3 percent was applied to the FY 1986 appropriated level of each PPA as delineated above, and therefore no Departmental or Agency discretion was involved in determining sequesterable amounts under the Act.

The second issue pertains to reallocation of remaining resources in order to ensure prioritization of programs. Executive branch Departments and agencies have been notified by the Office of Management and Budget (OMB) that post G-R-H reprogramming would be permissible subject to existing guidelines. Page 4 of OMB Bulletin No. 86-7 states:

> .... Although the Act requires this distribution in the President's order and requires a uniform percentage reduction of the budgetary resources among PPA's it does not disturb previously existing authority to reprogram budgetary resources after the reduction is in effect.

The Department has specific guidelines governing the reprogramming of agency funds and I would refer you to the memorandum dated March 12, 1986, from Bill Reise to Agency Administrative Officers detailing the procedures for requesting approval of reprogrammings, object class adjustments and reorganizations.

Finally, it is anticipated at this point in time that the application of G-R-H budget reductions in FY 1987 would operate in a manner consistent with that described above for FY 1986, if in fact, sequestration becomes necessary. However, in the absence of specific instructions and guidelines for FY 1987 from the central agencies and the Congress, it cannot be predicted with certainty that the implementation of the G-R-H law in the future will be the same as in the first year of its application (FY 1986).

Please do not hesitate to contact me if I can be of further assistance to you in your attempt to answer Congressional inquiries on this (or any other) matter.

U.S. Department of Labor

Office of the Assistant Secretary
for Administration and Management
Washington, D.C. 20210

Reply to the Attention of:

MAR 12

MEMORANDUM FOR: AGENCY ADMINISTRATIVE OFFICERS

FROM: WILLIAM R. REISE
Comptroller for the Department

SUBJECT: Reprogramming, Object Class Adjustments, and
Notification of Reorganization - Fiscal 1986

This memorandum updates the Departmental procedures for requesting approval of reprogrammings and object class adjustments for current year appropriations to comply with Senate requirements.

There are two types of submissions required of agencies, depending on: (1) whether the funding adjustment is being requested under established Congressional guidelines and thus constitutes a formal reprogramming which must go to OMB and the Congress or whether (2) the adjustment is being requested in compliance with Departmental guidelines on object class adjustments which would only require Under Secretary level approval before being implemented.

Please note that the changes to the 1986 enacted budget (whether by object class or activity), made in the President's 1987 budget request sent to Congress on February 5, are by definition approved by OMB, and may be considered reprogramming requests to the Congress in themselves. You will be notified by your Budget Office analyst if there are any exceptions to this. The base to be used when determining subsequent types of 1986 reprogrammings or adjustments is the 1986 column of the President's 1987 budget adjusted to reflect Gramm-Rudman reductions. These changes are reflected in your Agency's most recent apportionments or back-up to apportionments. Please note that the $250,000 adjustment (reprogramming or object class) threshold discussed in this memorandum applies not only to any individual changes but also to cumulative changes.

In addition this memorandum informs you of Departmental policy on compliance with the Congressional desire to receive prior notification regarding reorganizations. This will be discussed in number (3) below.

1. Formal Reprogramming

   A. Congressional Requirements
   Senate report language accompanying the 1986 Department of Labor appropriation is quite specific about the size and nature of reprogrammings and other adjustments that the Senate Appropriations Subcommittee is interested in reviewing. There are no comparable House provisions. Specifically, the Senate Report (No. 99-151) contains the following direction:

   (1.) The Senate is interested in reviewing agency reprogrammings which "may not change either the total amount available in an account or any of the purposes for which the appropriation is legally available, represent a significant departure from budget plans presented to the Committee in an agency's budget justifications."

   (2.) The Committee directs that reprogramming requests be made:

   -- prior to reprogramming funds in excess of ten (10) percent or $250,000, whichever is less, between programs, activities, or elements and;

   -- prior to taking actions involving less than the above mentioned amounts if such actions would have the effects of changing an agency's funding request in future years, or if programs or projects specifically cited in the Committee's reports are affected.

   B. In keeping with the direction provided by the Congress, an Agency should submit a request for reprogramming addressed to the Under Secretary, through the Office of Budget, no less than 45 days prior to the desired effective date of the reprogramming action. The automatic sequestration which went into effect on March 1, may require some agencies to redistribute cuts. The department will do all it can to expedite the processing of these necessary reprogrammings. The memorandum should include the following types of information in numbered paragraphs: (1) reason and amount, and what Senate criteria is met ($250,000, 10 percent of account, future year effect...); (2) source of funds and reason(s) they are available; (3) future budgetary effects; (4) cost savings or cost benefits;

(5) effect of reprogramming denial; and (6) any known OMB or Congressional interest. Attachment A contains the suggested memorandum outline. An activity table in the form of Attachment B should be included with the memorandum.

Attachments C through E contain suggested formats for preparing the official request for reprogrammings that must go to OMB, and to the respective Appropriations Committees. Drafts of these letters should be submitted with formal reprogramming requests to the Under Secretary via the Office of Budget. When a formal reprogramming is approved at the Under Secretary's level, the letters will be returned to the agency for completion of the OMB letter in final. The final reprogramming request to OMB must include the draft Congressional letters. Please note that the Senate letter is addressed to the Chairman of the full Appropriations Committee, while the House letter is sent to the Chairman of the Labor/HHS Appropriations Subcommittee. This reflects specific guidance from the committee staff.

2. Object Class Adjustment

Agencies wishing to make adjustments in object classes which are not covered by the Senate criteria for reprogramming are required to request the approval of the Under Secretary if the adjustments total $250,000 or more. This approval should be requested in a memorandum in the form of the outline in Attachment F. The memorandum should be submitted no less than thirty (30) days prior to the desired date of the adjustment. The following types of information should be included in the memorandum in numbered paragraphs: (1) reason for adjustment; (2) reason for the availability of excess funds; (3) effect on future budgetary actions; (4) cost savings or benefits derived; (5) effect of request denial; and (6) any known OMB or Congressional interest. An object class table in the form of Attachment G should be included with the memorandum.

3. Notification of reorganizations

The Senate report language (op cit) also requires that notification will be provided to the Congress regarding reorganization of offices, programs, or activities prior to the planned implementation of such reorganizations. For the purpose of meeting this requirement 'reorganization' will be defined as the establishment, revision, discontinuance or reassignment of a major function at the first level of organizational responsibility at the National (Headquarters) level as defined in Section 2026 of the DLMS 3-2000, Position Management and Organizational Review; and/or the highest or next level of organizational responsibility in the field. Changes below these levels (e.g., subcomponents of a major program at headquarters or third level organizations in the field) do not require Congressional notification. Establishment of individual positions, including deputies and special assistants, is also excluded from this requirement.

After completion of OASAM prior approval requirements and union consultation, the Agency Head will prepare a memorandum notifying Congress of the planned organizational changes and justification of such changes. The memorandum will be sent to the Office of the Comptroller, OASAM for formal transmittal to Congress by the Assistant Secretary for Administration and Management.

Any questions on these instructions in general should be submitted to Bryan Keilty, Departmental Budget Office. Any questions on applicability to individual accounts should be directed to the Office of Budget analyst for that account.

Attachments

Attachment A

MEMORANDUM FOR: UNDER SECRETARY OF LABOR

THROUGH: OFFICE OF BUDGET

FROM: JOHN A. DOE
Assistant Secretary for
(Agency name)

SUBJECT: Reprogramming Request for (Subject)

In accordance with Department of Labor requirements (Agency name) is requesting a reprogramming in the (state the area of reprogramming). This reprogramming is a to take place (date of reprogramming). Further information is provided below.

1. Reason
2. Source of Funds; Reason for Availability
3. Future Budgetary Effects
4. Cost Savings or Benefits
5. Effect of Reprogramming Denial
6. Known OMB or Congressional interest

For your convenience, enclosed are draft letters from the Secretary to OMB, and to the House and Senate Appropriations Subcommittees asking their approval of this request.

Enclosures

Attachment B

-2-

Agency Name
Salaries and Expenses

Obligations by Activity

Activity	Appropriation (Revised) 1/	Reprogrammed Level	Proposed Reprogramming (+) or (-)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
Total			

1/ Reflects Gramm-Rudman Reductions.

Attachment C

Honorable (Name of Director)
Director
Office of Management
  and Budget
Washington, D.C. 20503

Dear (Director's first name):

This letter is to request your approval to authorize the Department of Labor to reprogram (amount if applicable, Public Law number, Agency, and fiscal year). The reprogramming would (briefly state the fund and/or program change). As these funds are already included (if accurate) in (Agency name) approved budget under the Continuing Resolution (or Appropriation), no change in (Agency name) total appropriation is involved. (SUGGESTED FIRST PARAGRAPH)

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*                 JUSTIFICATION FOR REPROGRAMMING                      *
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Enclosed is a revised schedule for obligations by activity. The reprogramming involves funds in the same (or different) object class so no revision is to object class totals is necessary (or, a revised exhibit of object classes is also included).

C

We appreciate your consideration of this reprogramming request and hope it will receive your prompt attention. The request to the Congressional Committees will be forwarded in the form of the enclosed draft letters.

Sincerely,

(Name of Secretary)
Secretary of Labor

Enclosures
jd/JD

Attachment D

Honorable (Name of Chairman)
Chairman, Subcommittee on Labor,
Health and Human Services,
Education and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman (Last Name):

This letter is to request your approval to authorize the Department of Labor to reprogram (amount if applicable, Public Law number, Agency, and fiscal year). The reprogramming would (briefly state the fund and/or program change). As these funds are already included (if accurate) in (Agency name) approved budget under the Continuing Resolution (or Appropriation), no change in (Agency name) total appropriation is involved. (SUGGESTED FIRST PARAGRAPH)

JUSTIFICATION FOR REPROGRAMMING

Enclosed is a revised schedule for obligations by activity. The reprogramming involves funds in the same (or different) object class so no revision is to object class totals is necessary (or, a revised exhibit of object classes is also included).

D

This request has been approved by OMB (see attached letter) and is also being submitted to the Senate Subcommittee on Labor, Health and Human Services, and Education and Related Agencies, Committee on Appropriations. With the approval of both committees, we will proceed with the implementation of this change.

Sincerely,

(Name of Secretary)
Secretary of Labor

Enclosures
jd/JD

Attachment E

Honorable (Name of Chairman)
Chairman,
Committee on Appropriations
United States Senate
Washington, D.C. 20510

Dear Chairman (Last Name):

This letter is to request your approval to authorize the Department of Labor to reprogram (amount if applicable, Public Law number, Agency, and fiscal year). The reprogramming would (briefly state the fund and/or program change). As these funds are already included (if accurate) in (Agency name) approved budget under the Continuing Resolution (or Appropriation), no change in (Agency name) total appropriation is involved. (SUGGESTED FIRST PARAGRAPH)

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Enclosed is a revised schedule for obligations by activity. The reprogramming involves funds in the same (or different) object class so no revision is to object class totals is necessary (or, a revised exhibit of object classes is also included).

E

This request has been approved by OMB (see attached letter) and is also being submitted to the House Subcommittee on Labor, Health and Human Services, and Education and Related Agencies, Committee on Appropriations. With the approval of both committees, we will proceed with the implementation of this change.

Sincerely,

(Name of Secretary)
Secretary of Labor

Enclosures
jd/JD

Attachment F

MEMORANDUM FOR: UNDER SECRETARY OF LABOR

THROUGH: OFFICE OF BUDGET

FROM: JOHN A. DOE
Assistant Secretary for
(Agency Name)

SUBJECT: Object Class Adjustment Request

In accordance with Department of Labor requirements (Agency name) is requesting to make an object class adjustment (state the area of reprogramming and amount of funds involved). This object class adjustment is to take place (date of adjustment).

JUSTIFICATION FOR OBJECT CLASS ADJUSTMENT

We appreciate your consideration of this object class adjustment and hope it will receive your prompt attention.

Attachment G

Agency: ____________________

Account: ____________________

Object Class Adjustment
FY 19--

		FY 19-- Availability	Change Requested	Revised FY 19--
11.9	Total Personel Comp.....			
12.1	Personnel Benefits.....			
13.0	Benefits to Former Per.			
21.0	Travel/Transp. of Per..			
22.0	Transp. of Things......			
23.1	Rents-GSA..............			
23.2	Rents - other..........			
23.3	Communications, Utilities, etc........			
24.0	Printing...............			
25.0	Other Services.........			
	Working Capital Fund..			
26.0	Supplies...............			
31.0	Equipment..............			
32.0	Land/Structures........			
41.0	Grants.................			
42.0	Claims.................			
	Total Obligations			

* Includes Trust Fund Transfers

QUESTION 6(e)

Is it your understanding that the Secretary of Labor has total discretion within the agency to determine where savings will be taken?

ANSWER 6(e)

The Secretary had to take the reduction across the board by 4.3 percent in accordance with the law.

WRITTEN QUESTIONS FROM CHAIRMAN MURKOWSKI TO THE GENERAL ACCOUNTING OFFICE AND THE RESPONSES

FRANK H. MURKOWSKI, ALASKA, CHAIRMAN
ALAN K. SIMPSON, WYOMING
STROM THURMOND, SOUTH CAROLINA
ROBERT T. STAFFORD, VERMONT
ARLEN SPECTER, PENNSYLVANIA
JEREMIAH DENTON, ALABAMA
RUDY BOSCHWITZ, MINNESOTA
ALAN CRANSTON, CALIFORNIA
SPARK M. MATSUNAGA, HAWAII
DENNIS DECONCINI, ARIZONA
GEORGE J. MITCHELL, MAINE
JOHN D. ROCKEFELLER IV, WEST VIRGINIA
ANTHONY J. PRINCIPI, CHIEF COUNSEL/STAFF DIRECTOR
JONATHAN R. STEINBERG, MINORITY CHIEF COUNSEL/
STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

March 6, 1986

Honorable Charles A. Bowsher
Comptroller General of the United States
General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Bowsher:

The Veterans' Administration recently announced that it would curtail activity in the Home Loan Guaranty Program in order to comply with the guaranteed loan limitation imposed by the "Balanced Budget and Emergency Deficit Control Act of 1985".

Although the impact of the Fiscal Year 1986 Presidential sequester order issued pursuant to this Act certainly affected the guaranteed loan limitation of this program, the announced programmatic changes were the direct result of exceedingly low and inaccurate VA estimates of loan activity during Fiscal Year 1986.

On February 19, 1986, the Veterans' Administration issued a news release in which it stated its intent to withdraw its previously announced plans to impose certain loan limitations beginning on March 1, 1986. These limitations would have included denying requests for refinancing or partial or restored guaranties, as well as setting a $90,000 limit on loans. This announcement came at a time when legislation was pending which would temporarily alleviate the projected shortfall of new loan commitments under the program. This legislation (H.R. 4130) was passed by the Congress on February 25, 1986, and has been sent to the President. This legislation would, for purposes of implementing the Fiscal Year 1986 Presidential sequester order for new loan guaranty commitments, authorize a credit level of $18.2 billion, rather than the $12 billion previously established in the sequester order.

I am concerned with a statement contained in the Veterans' Administration's February 19, 1986 news release which stated "[t]he Veterans' Administration today announced that it will continue to operate its home loan guaranty program without restrictions until it reaches the loan commitment limit mandated by 1986 deficit control measures."

Section 252(e) of the "Balanced Budget and Emergency Deficit Control Act of 1985" states in pertinent part, ". . . no person who is or becomes eligible for benefits under any provision of law shall be denied eligibility by reason of any order issued under this part."

In the context of this limitation, I request a legal opinion by the Comptroller General on the following issues:

If the Veterans' Administration home loan program's guaranteed loan limitation is reached before the end of the fiscal year,

(1) can the Veterans' Administration legally deny or delay an eligible beneficiary's request for a new loan guaranty or would this violate section 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985; and

(2) can the VA legally deny or delay an eligible beneficiary's request for refinancing or for a partial or restored guaranty or would such action violate section 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985?

I am requesting similar opinions from the Veteran's Administration and the Office of Management and Budget. I would appreciate your cooperation in this important legal matter and I look forward to your response.

Sincerely,

Frank H. Murkowski
Chairman

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-221498.25

June 3, 1986

The Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

This responds to your request, dated March 6, 1986, regarding the Veterans' Administration's proposal to curtail activity in the Home Loan Guarantee Program to comply with the guaranteed loan limitation imposed by the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177). You specifically ask for our views as to whether the VA may legally deny or delay an eligible beneficiary's request for a new loan guarantee, for refinancing, or for a partial or restored guarantee, in light of section 252(e) of the Act. That section provides that no person who is or becomes eligible for benefits under any provision of law shall be denied eligibility by reason of any sequestration order issued under the Act.

Section 252(e) ensures that those eligible for entitlements will not be considered to have lost that eligibility by reason of reductions required by the Act. In our view, however, a distinction exists between an entitlement created under law and the budgetary resources necessary to see that such an entitlement is fulfilled. While Public Law 99-177 does not affect the underlying entitlement, in some cases--including the VA's loan guarantee program--it has reduced the budgetary resources provided to carry out the entitlement. When additional resources are made available, for example through legislation such as that recently enacted by the Congress with respect to this program, the entitlement may be fulfilled.

Your letter indicates that the VA has decided to operate its home loan guarantee program without restriction until it reaches the loan commitment limit mandated by Public Law 99-177. This action appears reasonable in light of the recent passage of two loan guarantee limit extensions (in Public Law 99-133 and Public Law 99-322). If these extensions do not provide sufficient authority for the VA to meet its obligations under the program, it would be appropriate for the agency to take reasonable steps to limit the provision of loan guarantees to stay within budgetary resources. This would not constitute a denial of eligibility, but instead a denial of benefits provided in fulfillment of that eligibility, due to a lack of budgetary resources.

We hope that the foregoing is of assistance to you.

Sincerely yours,

for Milton J. Socolar

Comptroller General
of the United States

WRITTEN QUESTIONS FROM CHAIRMAN MURKOWSKI TO THE OFFICE OF MANAGEMENT AND BUDGET

FRANK H MURKOWSKI ALASKA CHAIRMAN

STROM THURMOND SOUTH CAROLINA
ROBERT T STAFFORD VERMONT
ARLEN SPECTER PENNSYLVANIA
JEREMIAH DENTON ALABAMA
RUDY BOSCHWITZ MINNESOTA
ALAN CRANSTON CALIFORNIA
SPARK M MATSUNAGA HAWAII
DENNIS DeCONCINI ARIZONA
GEORGE J MITCHELL MAINE
JOHN D ROCKEFELLER IV WEST VIRGINIA

ANTHONY J PRINCIPI CHIEF COUNSEL/STAFF DIRECTOR
JONATHAN R STEINBERG MINORITY CHIEF COUNSEL/
STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

March 6, 1986

Honorable James C. Miller, III
Director
Office of Management and Budget
Executive Office Building
Washington, DC 20503

Dear Mr. Miller:

The Veterans' Administration recently announced that it would curtail activity in the Home Loan Guaranty Program in order to comply with the guaranteed loan limitation imposed by the "Balanced Budget and Emergency Deficit Control Act of 1985".

Although the impact of the Fiscal Year 1986 Presidential sequester order issued pursuant to this Act certainly affected the guaranteed loan limitation of this program, the announced programmatic changes were the direct result of exceedingly low and inaccurate VA estimates of loan activity during Fiscal Year 1986.

On February 19, 1986, the Veterans' Administration issued a news release in which it stated its intent to withdraw its previously announced plans to impose certain loan limitations beginning on March 1, 1986. These limitations would have included denying requests for refinancing or partial or restored guaranties, as well as setting a $90,000 limit on loans. This announcement came at a time when legislation was pending which would temporarily alleviate the projected shortfall of new loan commitments under the program. This legislation (H.R. 4130) was passed by the Congress on February 25, 1986, and has been sent to the President. This legislation would, for purposes of implementing the Fiscal Year 1986 Presidential sequester order for new loan guaranty commitments, authorize a credit level of $18.2 billion, rather than the $12 billion limitation previously established in the sequester order.

I am concerned with a statement contained in the Veterans' Administration's February 19, 1986 news release which stated "[t]he Veterans' Administration today announced that it will continue to operate its home loan guaranty program without restrictions until it reaches the loan commitment limit mandated by 1986 deficit control measures."

Section 252(e) of the "Balanced Budget and Emergency Deficit Control Act of 1985" states in pertinent part, ". . . no person who is or becomes eligible for benefits under any provision of law shall be denied eligibility by reason of any order issued under this part."

In the context of this limitation, I request a legal opinion by the Office of Management and Budget on the following issues:

If the Veterans' Administration home loan program's guaranteed loan limitation is reached before the end of the fiscal year,

(1) can the Veterans' Administration legally deny or delay an eligible beneficiary's request for a new loan guaranty or would this violate section 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985; and

(2) can the Veterans' Administration legally deny or delay an eligible beneficiary's request for refinancing or for a partial or restored guaranty or would such action violate section 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985?

I am requesting similar opinions from the Veteran's Administration and the General Accounting Office. I would appreciate your cooperation in this important legal matter and I look forward to your response.

Sincerely,

Frank H. Murkowski
Chairman

(Note: No response was received from OMB.)

WRITTEN QUESTIONS FROM CHAIRMAN MURKOWSKI TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

February 7, 1986

Mr. Don Ivers
General Counsel
Veterans' Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Don:

Please provide me with the opinion of the General Counsel as how the VA will apply the sequester order under Public Law 99-177 (so-called Gramm/Rudman/Hollings) to entitlement benefit programs administered by the Veterans' Administration. Does a sequester order require or permit the amount of an entitlement paid to a veteran to be reduced from the amount of an entitlement paid to a veteran to be reduced from the amount specified in title 38? Please address each program affected and the way in which the sequester will be carried out.

Thank you for your expedited response to this request.

Sincerely,

Frank H. Murkowski
Chairman

(Note: The VA did not submit a formal General Counsel's opinion.)

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

MAR 6 1986

In Reply Refer To:

Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed are partial responses to the questions you submitted on February 13, 14, and 18 and Senator Cranston submitted on February 7, 1986.

At this time, we are in the continuing process of providing responses to a number of issues raised in your correspondence of February 7, 13, 14, and 18. Since the later three letters specifically concern the same areas that were more generally addressed in your letter of the 7th, we believe that our answers to the later correspondence will satisfy the needs you expressed in your February 7th correspondence.

We will be sending additional responses as we complete the review and clearance process. Please excuse our delay in forwarding these responses to you.

Sincerely,

Everett Alvarez

EVERETT ALVAREZ, Jr.
Acting Administrator

Enclosure

"America is #1—Thanks to our Veterans"

[illegible]

ALAN K SIMPSON WYOMING
STROM THURMOND SOUTH CAROLINA
ROBERT T STAFFORD VERMONT
ARLEN SPECTER PENNSYLVANIA
JEREMIAH DENTON ALABAMA
RUDY BOSCHWITZ MINNESOTA

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GEORGE J MITCHELL MAINE
JOHN D ROCKEFELLER IV WEST VIRGINIA

ANTHONY J PRINCIPI CHIEF COUNSEL/STAFF DIRECTOR
JONATHAN R STEINBERG MINORITY CHIEF COUNSEL/
STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

February 12, 1986

Honorable Everett Alvarez
Acting Administrator
Veterans' Administration
810 Vermont Avenue, NW
Washington, DC 20420

Dear Ev:

I am rather disturbed at the perspective provided by the recent articles on the Veterans' Administration's Home Loan Guaranty program. I have read a UPI release on the current credit limitations dilemma facing the program, and I feel the quote provided by the VA is extremely misleading. Mr. Ozzie Garza is quoted as saying, "We had originally intended to get $12 billion to guarantee our loans, but Gramm-Rudman will bring that down to $11 billion and at that rate probably by midyear we would,have reached that limit."

This quote seems to imply that Gramm-Rudman was the cause of all the VA's expected problems regarding projected loan activity. It is true that Gramm-Rudman requires a 4.3% sequester in FY 1986 for the VA's loan guaranty program. This means that for the first time the VA's loan guaranty program is faced with a limited amount of credit extension authority. The estimated loan volume of $12 billion used by the VA is not an accurate forecast of loan activity for fiscal year 1986. The VA was aware of the enactment of this law and its requirements in advance of the January 15 "snapshot" of program activity levels required by Gramm-Rudman, and could have updated the estimate of loan activity that was to serve as the baseline from which a sequester would occur. Gramm-Rudman is not the cause of this crisis. The crisis was actually triggered by a poor estimate of program activity for FY 1986 which has resulted in fears of curtailed program activities. It is difficult for me to understand how the VA provided such a low estimate of loan activity in light of the reductions in interest rates, and the loan volume during the fourth quarter of FY 1985 and the first quarter of FY 1986. This information is included in the publication, "VA's Loan Guaranty Highlights". A more up-to-date forecasting of the loan activity level would have helped greatly in avoiding unnecessary fears regarding curtailment of this important benefit.

As I am sure you are aware, to help alleviate this problem, I have co-sponsored legislation that has been introduced in both the Senate and the House which would provide for a more accurate baseline from which a 4.3% reduction would occur. It is my sincere hope that we will be successful in getting this legislation enacted in the very near future. Should this prove not to be the case, the VA will undoubtedly be forced to initiate certain program changes for the balance of FY 1986.

There have been a number of program changes discussed informally between our respective staffs and widely reported in the media; however, as of yet this Committee has received no official confirmation of any program changes which may occur as a result of the 4.3% sequester. I would appreciate your comments on this matter to include the following:

- program changes which will be implemented should the pending legislation not be enacted and how such changes will meet the imposed requirements,
- alternatives which were considered and, the reasons for deciding against them,
- your General Counsel's comments on the legality of the proposed changes, taking into special consideration section 252(e) of the "Balanced Budget and Emergency Deficit Control Act of 1985",
- full details on how program changes will be implemented, including dates of implementation and who will be affected.

I would also appreciate your views on the Home Loan provisions included in S. 1887, which passed the Senate last year and is presently pending in the House Veterans' Affairs Committee. I received handwritten VA comments in support of those provisions; however, in light of the fact that I intend to introduce new legislation to include similar provisions, your official comments would be most helpful.

I am confident that through a cooperative effort we will ensure that the VA Home Loan program continues to provide this Nation's veterans with one of the most helpful and productive benefits available.

Sincerely,

Frank H. Murkowski

Frank H. Murkowski
Chairman

cc: Robert O'Toole

MAR 14 1986

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your letter of February 12, 1986, regarding changes to the VA Loan Guaranty program required by the Balanced Budget and Emergency Deficit Control Act of 1985, commonly referred to as the Gramm-Rudman Act.

Under the Presidential sequestration order issued pursuant to the Gramm-Rudman Act, the amount of new loan guaranty commitments VA could make in Fiscal Year 1986 was originally limited to approximately $11.5 billion. On March 7, 1986, the President signed Pub. L. No. 99-255 which increased the limit applicable to the VA Loan Guaranty program to $17.2 billion, less 4.3 percent.

If this new limit is reached, VA will stop guaranteeing loans for the remainder of the fiscal year. Automatic lenders will be advised to stop making such loans, and VA will not issue commitments to prior approval lenders.

As was widely reported in the media, VA initially considered imposing three temporary limitations on the program for the remainder of this fiscal year. These limitations were: not guaranteeing loans for veterans who had previously obtained a VA guaranteed or direct home loan; not guaranteeing refinancing loans; and limiting the amount of the loan eligible for guaranty to $90,000. It was our hope that these measures would have enabled us to continue the program for the remainder of the fiscal year, serving at least first-time home purchasers. On review, it became apparent that these measures would not have prevented us from reaching the original ceiling early in the year. Thus, there is no plan to implement these restrictions.

Should VA reach the ceiling and VA were required to stop guaranteeing loans, we do not believe this cutoff would violate section 252(e) of the Gramm-Rudman Act. This section provides that "no person who is or becomes eligible for benefits under any . . . law shall be denied eligibility by reason of any order issued under" the Gramm-Rudman Act. The Gramm-Rudman limitation is legally binding on the VA. Once the ceiling is reached, the VA is without authority to guarantee any more loans for the remainder of the fiscal year. While veterans who meet the statutory criteria remain eligible to receive guaranteed loans, such eligibility may not be honored in excess of the congressionally mandated limit.

VA is currently taking steps to procure the services of an independent consultant to assist the Department of Veterans Benefits in developing an accurate forecasting methodology on which to base future estimates of home loan volume. With a systematic forecasting procedure in place, we are confident the estimating problems experienced this year can be avoided in the future.

You also requested that we provide comments on the home loan provisions of S. 1887 which passed the Senate December 2, 1985. We will be providing you with a report on these provisions in the near future.

Sincerely,

EVERETT ALVAREZ, JR.
Acting Administrator

DISPATCHED
MAR 1 7 1986
ADMINISTRATOR'S OFFICE

RECEIVED
MAR 1 3 1986
ADMINISTRATOR'S OFFICE

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FRANK H. MURKOWSKI, ALASKA, CHAIRMAN

ALAN K. SIMPSON, WYOMING
STROM THURMOND, SOUTH CAROLINA
ROBERT T. STAFFORD, VERMONT
ARLEN SPECTER, PENNSYLVANIA
JEREMIAH DENTON, ALABAMA
RUDY BOSCHWITZ, MINNESOTA

ALAN CRANSTON, CALIFORNIA
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JOHN D. ROCKEFELLER IV, WEST VIRGINIA

ANTHONY J. PRINCIPI, CHIEF COUNSEL/STAFF DIRECTOR
JONATHAN R. STEINBERG, MINORITY CHIEF COUNSEL/
STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

March 6, 1986

Honorable Everett Alvarez, Jr.
Acting Administrator
Veterans' Administration
810 Vermont Avenue, NW
Washington, DC 20420

Dear Ev:

On February 19, 1986, the Veterans' Administration issued a news release in which it stated its intent to withdraw previously announced plans to impose certain loan limitations on the operation of the Home Loan Guaranty Program. The news release also stated that the Veterans' Administration will continue to operate its home loan guaranty program without restrictions until it reaches the loan commitment limit mandated by 1986 deficit control measures. It appears that these statements were made in anticipation of a legislative remedy which culminated in the passage of H.R. 4130 by the Congress on February 25, 1986, which authorizes a more realistic level of loan volume for Fiscal Year 1986.

I am concerned still, that in spite of this legisation to remedy the immediate crisis, that the guaranteed loan limitation may be reached before the end of this fiscal year and may result in the denial of loan guaranty benefits to eligible beneficiaries of this program.

On February 12 and 13, 1986, I requested the Veterans' Administration to provide information on its previously announced plans to curtail certain aspects of the program in order to comply with the guaranteed loan limitation required by the Presidental sequester order. I also asked whether the denial of new guaranties, partial or restored guaranties and refinancing requests would violate section 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985, which states in pertinent part, ". . . no person who is or becomes eligible for benefits under any provision of law shall be denied eligibility by reason of any order issued under this part." I have not yet received any response.

In the context of the statutory limitation imposed for Fiscal Year 1986 by P.L. 99-177, and as increased by H.R. 4130, I request a legal opinion by the Veterans' Administration on the following issues:

If the Veterans' Administration home loan program's guaranteed loan limitation is reached before the end of the fiscal year:

(1) can the Veterans' Administration legally deny or delay an eligible beneficiary's request for a new loan guaranty or would this violate section 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985; and

(2) can the Veterans' Administration legally deny or delay an eligible beneficiary's request for refinancing or for a partial or restored guaranty or would such action violate section 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985?

I am requesting similar opinions from the Office of Management and Budget and the General Accounting Office. I appreciate your cooperation in this important legal matter and I look forward to your response.

Sincerely,

Frank H. Murkowski
Chairman

cc: Mr. Donald Ivers

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

APR 14 1986

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

I am pleased to respond to your letter of March 6, 1986, regarding the impact of the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177) on the issuance of Veterans Administration new loan guarantee commitments in Fiscal Year 1986, and whether a veteran's request for a loan guaranty may be delayed under the Act.

As you are aware, the Presidential order to sequester funds was issued on February 1, 1986, and the Fiscal Year 1986 reductions took effect on March 1, 1986. The sequester order was applicable to new loan guarantee commitments and the limitation imposed on the amount of Veterans Administration new loan guarantee commitments was $11.5 billion.

The Veterans Administration initially considered imposing three temporary limitations on the Loan Guaranty Program because of the impact of the Balanced Budget and Emergency Deficit Control Act of 1985. These limitations were as follows: limiting the amount of the loan eligible for guaranty to $90,000; no longer guaranteeing loans for veterans who had previously obtained a Veterans Administration guaranteed or direct home loan; and no longer guaranteeing refinancing loans. It was anticipated that these actions would have enabled the Agency to continue the program for the remainder of the year, serving at least first-time home purchasers. However, it became apparent that these proposals would not have prevented the Agency from reaching the limitation imposed by the President's sequestration order by April 1, 1986.

The news release issued on February 19, 1986, to which you refer in your letter, announced the withdrawal of the plan to implement these three program restrictions. The news release did mention that there were several proposals in Congress to raise the loan guarantee commitment level. Legislation was enacted and on March 7, 1986, the President signed H. R. 4130 (Public Law 99-255), which increased the amount of new loan guarantee commitments to $18.2 billion reduced by 4.3 percent.

2.

Honorable Frank H. Murkowski

Concern is expressed in your letter that even with the enactment of this new legislation, the guaranteed loan limitation may be reached before the end of Fiscal Year 1986. If this limitation is reached, you question whether a veteran's request for (1) a new guaranteed loan, or (2) for a refinancing loan or use of partial or restored entitlement may be denied or delayed in view of section 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985.

This limitation, whether established under the President's sequestration order or an alternative limit enacted by the Congress, is legally binding on the Agency. We are without authority to exceed a congressionally imposed ceiling on the allowable level of new loan guarantee commitments for Fiscal Year 1986. We do not believe that the suspension of the Loan Guaranty Program is in conflict with section 252(e) of the Act. This section provides that "no person who is or becomes eligible for benefits under any provision of law shall be denied eligibility by reason of any order issued under this part." It is our view that veterans who meet the statutory title 38 criteria remain eligible to receive guaranteed loans. However, such eligibility may not be honored in excess of the congressionally mandated limit.

A response to your letter of February 12 was mailed on March 14. With regard to your letter of February 13 which posed 10 questions, responses to several questions have been provided. Responses to the remaining questions will be forwarded to you at the earliest possible time.

Sincerely,

THOMAS K. TURNAGE
Administrator

QUESTIONS ON THE IMPLEMENTATION OF THE FY 1986 SEQUESTER ORDER

QUESTION:

1. Construction:

(a) Please provide: a complete listing of the projects which will be affected, including any unobligated balance for each project; the amount of savings to be achieved from each affected project; the rationale and methodology used to determine each project's savings; how the construction plans will be altered (including reduction in beds if any and the type of beds to be reduced) for each project as a result of the implementation of the sequester; the impact on the delivery of patient care and FTEE, particularly any impact on delays in activations and FTEE affected thereby; and the estimated future cost impact due to any delays.

(b) (i) Please provide details on whether any contractual obligation will be affected by implementation of the sequester order for major and minor construction activities, including a legal analysis on the propriety of any change to a contractual obligation.

(ii) Will any prior obligated appropriation funds be affected?

Response: Attached are complete listings of FY 1986 major projects and line items, and minor line item categories as included in the FY 1987 Congressional Budget Submission. These show that reductions of 4.3% were made to all amounts derived from the FY 1986 appropriation for each project and line item in the major program, and in all line item categories in the minor program.

In the major program, none of the projects are under construction. Designs will be restudied and revised if necessary to achieve the dollar reductions and it is planned to make the necessary changes within current schedules. In most cases, it appears that the new lower costs can be achieved with little, if any, impact on patient care, FTEE, and activations. If it is found that there are undesirable impacts, scope reductions or reprogrammings of selected projects may be proposed.

(b)(i) No contractual obligations will be affected by the sequestration order. Changes in design for some contracts may be required to accomplish redesigns as mentioned above.

(b)(ii) No.

CHANGES FROM ORIGINAL 1986 APPROPRIATION
(dollars in thousands)

The chart below reflects the major FY 1986 breakdown by project within category based on P.L. 99-160 versus the breakdown based on P.L. 99-177.

Location	Description	Original Estimated Cost	1986 Approp.	Current Estimated Cost	Adj. for P.L. 99-177
A. Medical Program:					
Replacement and Modernization:					
Allen Park, MI	Replacement and Modernization	$195,600	$ 26,760	$194,763	$- 837
Houston, TX	Replacement and Modernization	252,000	226,800	244,905	-7,095
Mountain Home, TN	Bed Towers and Renovation	70,300	59,000	68,454	-1,846
Philadelphia, PA	Clinical Addition, Renovation, Parking and 240-bed Nursing Home Care Unit	119,300	101,600	116,122	-3,178
Nursing Home Care:					
Amarillo, TX	120-bed Nursing Home Care Unit	6,500	6,500	6,296	- 204
Tucson, AZ	120-bed Nursing Home Care Unit	6,800	6,800	6,588	- 212
Domiciliaries:					
Temple, TX	408-bed Replacement Domiciliary	17,300	17,300	16,759	- 541
Wood, WI	Renovate Building 43 for Domiciliary	6,400	6,400	6,200	- 200
Other Improvements:					
Advance Planning Fund:					
Various Stations		4,000	4,000	3,875	- 125
Asbestos Abatement:					
Various Stations		35,000	35,000	33,905	-1,095
Clinical Improvements:					
Big Spring, TX	Renovate Surgery	3,700	3,700	3,584	- 116
Togus, ME	Clinical Improvements Building 200	30,700	30,700	29,740	- 960
Design Fund:					
Various Stations		15,000	15,000	14,531	- 469
Electrical Improvements:					
Hampton, VA	Electrical Systems Modernization	2,100	2,100	2,034	- 66
Long Beach, CA	Upgrade Secondary Electrical Distribution	5,300	5,300	5,134	- 166
Poplar Bluff, MO	Electrical Distribution System Improvements	2,000	2,000	1,937	- 63
Fire and Safety Improvements:					
Chicago(West Side), IL	Fire and Safety and Patient Privacy Improvements	6,600	6,600	6,393	- 207
Cleveland(Brecksville), OH	Fire and Safety Improvements	2,700	2,700	2,616	- 84
Cleveland(Wade Park), OH	Fire and Safety Improvements	5,200	5,200	5,037	- 163
Indianapolis, IN	Fire and Safety Improvements	5,000	5,000	4,844	- 156
Jackson, MS	Install Sprinkler System	3,000	3,000	2,906	- 94
Knoxville, IA	Fire and Safety Improvements	3,700	3,700	3,584	- 116
Topeka, KS	Fire and Safety, Patient Privacy and Electrical Improvements	18,150	10,000	17,837	- 313

CHANGES FROM ORIGINAL 1986 APPROPRIATION (Continued)
(dollars in thousands)

Location	Description	Original Estimated Cost	1986 Approp.	Current Estimated Cost	Adj. for P.L. 99-177
General Projects:					
Brooklyn(St. Albans Division), NY	Modernize Kitchen and Satellite Dining Areas	$ 4,800	$ 4,800	$ 4,650	$- 150
Chicago(West Side), IL	Renovation of Buildings 11A and 11B, Phase II	18,000	18,000	17,437	- 563
Coatesville, PA	New Kitchen and Dining Hall	6,300	6,300	6,103	- 197
Durham, NC	Boiler Plant	2,200	2,200	2,131	- 69
Hines, IL	180-bed Psychiatric Replacement Facility	23,000	23,000	22,281	- 719
Lyons, NJ	Renovate Buildings 7 and 57	13,600	13,600	13,174	- 426
St. Louis(Jefferson Barracks Division), MO	Remodel Building 53	9,900	9,900	9,590	- 310
Tomah, WI	Modernize Buildings 403 and 404 ..	6,100	6,100	5,910	- 190
Seismic:					
St. Louis(Jefferson Barracks Division), MO	Seismic Corrections	15,500	15,500	15,015	- 485
San Diego, CA	Non-structural Seismic Corrections	6,300	6,300	6,103	- 197
B. National Cemetery Program:					
Florida	Develop 13,000 Gravesites and Construct Administration Building	6,500	6,500	6,296	- 204
	Subtotal	$928,550	$697,360	$906,734	$-21,816
	Less: Design Fund		- 10,000		
	Reprogramming	...	-180,000	...	...
	TOTAL	$928,550	$507,360	$906,734	$-21,816

CHANGES FROM ORIGINAL 1986 APPROPRIATION
(dollars in thousands)

The chart below reflects the minor FY 1986 category breakdown based on P.L. 99-160 versus the new breakdown based on P.L. 99-177.

	1986 APPROPRIATION	WITH 4.3% REDUCTION 1/
A. Medical Program	$ 92,136	$ 88,174
Nursing home care	10,000	9,570
Research and education	4,000	3,828
Outpatient improvements	1,000	957
Other improvements	77,136	73,819
Clinical improvements	(12,700)	(12,154)
Electrical improvements	(2,000)	(1,914)
Fire and safety improvements	(6,000)	(5,742)
General projects	(17,436)	(16,686)
Heating, ventilating, and air conditioning	(3,000)	(2,871)
Seismic improvements	(2,000)	(1,914)
Miscellaneous projects	(34,000)	(32,538)
B. Regional Office Program	2,000	1,914
C. National Cemetery Program	4,400	4,211
D. Computer Centers	2,000	1,914
E. Emergency Fund	500	478
F. General Administration	35,914	34,370
Total, budget authority	$136,950	$131,061

1/ This column reflects the effects of P.L. 99-177, the Balanced Budget and Emergency Deficit and Control Act of 1985.

QUESTION:

2. Offsetting receipts: The sequester order requires reductions to the following accounts due to a 4.3% reduction for "offsetting collections":

- special therapeutic and rehabilitation activities fund 401(C)-off.coll: $2.325 million base
  $100,000 sequester
- canteen service revolving fund
  401(C)-off.coll: $188.461 million base
  $8.104 million sequester
- operations and maintenance
  401(C)-off.coll: $144,000 base
  $6,000 sequester
- Section 255 (e) of the "Balanced Budget and Emergency Deficit Control Act of 1985" states that "offsetting receipts and collections shall not be reduced under any order issued under this part."

  (a) On what authority are the sequesters for these VA accounts based?

  (b) Please provide an interpretation of how the requirements of this section (255(e)) are reconciled with the "offsetting collections" pursuant to section 401(C) of the Congressional Budget Act of 1974, as revised by the "Balanced Budget and Emergency Deficit Control Act of 1985"?

RESPONSE:

2(a). As stated by the Comptroller General in his February 7, 1986, opinion to the Honorable G. V. (Sonny) Montgomery, under section 255(e) of the Act, offsetting collections for credit to revolving funds are not to be reduced. Programs financed from these collections, however, are subject to sequestration. Section 251(a)(3)(F)(iv)(I) provides for reductions in a variety of budgetary resources, including "spending authority." The definition of spending authority was broadened under section 211 of Public Law 99-177 to include the authority to make payments by the United States, including "payments from revolving funds," the budget authority for which is not provided in advance by appropriation acts.

2(b). Because payments into revolving funds such as the Veterans' Canteen Service revolving fund are not to be reduced, but expenditures from such funds are to be reduced, the sequestration complies with the requirements of section 255(e).

Question: 2.c. How will the sequestered amounts for the offsetting collections be implemented for each of these accounts and what impact will the implementation of the sequester order have on obligations in each account and the operation of activities funded by each account?

Answer: The Veterans Canteen Service is studying several actions that will reduce the obligation level by $8,104,000. These actions include reducing equipment purchase, inventory reductions, shortening Canteen operating hours and may include reducing employment through attrition. These actions will also reduce revenues, and may also reduce the "extra" profit to be turned over to the treasury.

We now anticipate that there will be no impact on the Special Therapeutic and Rehabilitation Activities Fund, because current estimated obligation level is within the post-GRH obligation level.

Question: 2.d. Please provide a detailed analysis on how the obligations in the Canteen Service Revolving Fund were allocated between acquisitions and direct operations.

Answer: (in thousands)

Cost of goods sold (purchase of merchandise for resale)	$117,784
Direct Operations	
Salaries and Wages	$ 46,399
Supplies	4,144
Repairs	717
Occupancy	3,320
Employee Benefits	6,761
Cash Shortages	16
Other Direct Operating Costs	600
Temporary Travel	469
Permanent Travel	689
Postage	145
Employee Awards	278
Paid Expense	51
Employee Compensation and State Unemployment	390
Printing and Reproduction	245
Miscellaneous Administrative and Accounting	282
Increase in Inventories	1,644
Increase in Undelivered Orders	3,000
	$ 69,150

Question: 2.(e)(i) What impact will the sequester order have on the special therapeutic and rehabilitation activities fund, specifically on veterans' access to, and involvement in, work rehabilitation programs?

Answer: No impact is anticipated as stated in the previous answer, because the current projected obligation level is now estimated to be within the post-GRH level. If obligation levels rise above our estimates, controls will be put in place to limit total obligations which could reduce the number of veterans participating.

Question: 2.(e)(ii) What percentage of veterans participating in the program would be denied participation in the future as a result of a sequester?

Answer: No reduction is anticipated. If obligations do rise above estimates, the percentage of veterans impacted would be dependent upon how much revised estimates exceed obligation levels and in what month of the fiscal year action is taken.

Question: 2.(e)(iii) What impact would this have on their rehabilitation?

Answer: Although present estimates indicate no impact, the possibility exists that some veterans would be impacted this fiscal year but the effect if any, on their rehabilitation would be veteran specific and cannot be estimated at this time.

Question 3. Insurance accounts and revolving funds: Section 255(g)(2) provides that "prior legal obligations of the Government in the following [VA] budget accounts and activities shall be exempt from any order issued ..."

- VA, Loan Guaranty Revolving Fund
- VA, National Service Life Insurance Fund
- VA, Service-Disabled Veterans Insurance Fund
- VA, Servicemen's Group Life Insurance Fund
- VA, United States Government Life Insurance Fund
- VA, Veterans' Insurance and Indemnities
- VA, Veterans' Reopened Insurance Fund
- VA, Veterans' Special Life Insurance Fund

(a) Please define for each account, what the VA interprets a "prior legal obligation" to include and what would be excluded from the definition of "prior legal obligation"?

Answer 3(a). With regard to the VA insurance programs, all fund activities other than new policy loans clearly constitute prior legal obligations. The sequestration order does, of course, require limitations on new policy loans. In the Administration's view these are not "prior legal obligations." The question of whether this constitutes "prior legal obligation" is currently being reviewed by the Comptroller General (at the request of the Chairman of the House Committee on Veterans' Affairs).

With regard to the Loan Guaranty Revolving Fund, loans guaranteed prior to March 1, 1986, are protected. In addition, funds within the Loan Guaranty Revolving Fund are available to cover potential defaults on VA guaranteed loans and on loans sold with recourse, which by virtue of contract and law must be paid in the event of default. While these funds are not obligated pending default, these funds must be available upon default as the VA can not avoid this legal liability and must have these funds available to meet the default exposure.

Question: 3 (b). Please provide the full analysis and underlying assumptions used in the determination of the direct loan limitation (and guaranteed loan limitation with respect to the loan guaranty revolving fund) amounts for the following accounts which are included in the sequester order:

- Veterans' insurance and indemnities
- Veterans' reopened insurance fund
- Service-disabled veterans' insurance fund
- National service life insurance fund
- U.S. Government life insurance fund
- Veterans' special life insurance fund
- Vocational rehabilitation revolving fund
- Education loan fund
- Direct loan revolving fund
- Loan guaranty revolving fund

Answer: 3 (b). The response to question 3 (a) provides the premise under which the sequestration of funds was based. In respect to the specific programs, the following provides how the reduction was taken. The 1986 policy loan obligations in each government life insurance program were reduced by 4.3 percent. The 1986 Vocational Rehabilitation Revolving Fund and the Education Loan Fund loan limitations were also reduced by 4.3 percent. The Direct Loan Revolving Fund is also subject to the 4.3 percent reduction. The effect on the Loan Guaranty program is to reduce the 1986 total dollar volume of new loans guaranteed by 4.3 per cent.

Question 3.(c): Please describe in detail, how the VA intends to implement sequester requirements, and new loan obligations, limitations, and guarantee commitments for the accounts listed in (b).

Answer 3.(c): To limit policy loan obligations in the Government life insurance funds as a result of the Balanced Budget and Emergency Deficit Control Act of 1985, the Agency plans to maintain the policy loan interest rate at 11 percent for the remainder of the fiscal year. The FY 1986 budget estimates for policy loan obligations were based on the assumption that the policy loan interest rate would be lowered to 9 percent at the beginning of the fiscal year. The current 11 percent rate has, in effect, already resulted in a level of borrowing below the budget estimates for the National Service Life Insurance (V), the Veterans Insurance and Indemnities (H) and the Veterans' Special Life Insurance (RS/W) programs. Current estimates indicate that these 3 programs will stay under OMB's policy loan obligation limitations.

It appears, however, that even with an 11 percent interest rate, the Veterans Reopened Insurance (J) and the Service-Disabled Veterans Insurance (RH) programs would exceed the limitation. It should also be remembered that in the United States Government Life Insurance (K) program the interest rate is fixed by Title 38 at 5 percent. The Agency is currently reviewing what administrative steps can and need to be made in order to manage the policy loan activity for these programs within the limitation while still operating the programs through the fiscal year.

The Vocational Rehabilitation Revolving Fund loan limitation has been reduced from a level of $1,069,000 to a new level of $1,023,000. By implementing a 13.1 percent rate reduction in the subsistence allowance for Chapter 31 trainees, effective March 1, 1986. The maximum loan amount would also automatically be reduced from $620 to $538.

The Direct Loan limitation was reduced from a pre-sequestered level of $989,000 to a new level of $946,000. Since the Agency's estimate for this program is $235,000, sequestration should not have an impact on this program.

In the Education Loan program the loan limitation has been reduced from $50,000 to $48,000. Based on actual experience through February 1986 and the level of applications pending, it appears that the loan limitation has already been reached. As a result, it has become necessary to close the education loan program.

In the Loan Guaranty program, Public Law 99-255 increased the new loan guaranty base amount (prior to sequestration) to $18.2 billion. The new guaranty loan level after sequestration would be $17.4 billion. It is felt that at this revised level steps can be taken to insure the operation of the program through the fiscal year. The Agency is still considering what actions may be necessary to insure the operation of this program.

Question: 3.(d)(i) Does the VA anticipate that any new loan to eligible policyholders under any of the VA insurance programs would be reduced or denied, or would the interest rates charged on new loans to eligible policyholders be adjusted in order to meet the sequester guidelines?

Answer: 3.(d)(i) As mentioned in the response to question 3(c), it is estimated that maintaining the loan interest rate at 11 percent will allow the Agency to remain within the policy loan limitation for the National Service Life Insurance, Veterans Insurance and Indemnities and the Veterans Special Life Insurance programs. However, it is estimated that additional administrative action will be required in order to continue the operation of the USGLI, VRI and SDVI programs through the fiscal year. The Agency is currently reviewing administrative actions that can be taken to continue the operation of these programs.

Question: 3.(d)(ii) Would any or all of these options violate any contractual obligation of the VA to an eligible policyholder?

Answer: 3.(d)(ii) The Comptroller General, who is responsible for determining the statutorily required nature and extent of outlay reduction, included the limitations on direct policy loans in his January 20 report to the President. In doing so, he apparently concluded that (1) the sequestration requirements of the Act are broad enough to encompass policy loans, and (2) the Government may lawfully restrict policy loan availability.

Question: 3.(d)(iii) If any or all of the options listed in (d)(i) above are determined to present a legal bar to implementation of the FY 1986 sequester requirement, what other options will be VA pursue to comply with the sequester order?

Answer: 3.(d)(iii) The Agency is currently not considering any other options should the options discussed in 3(d)(i) be determined to present a legal bar to implementation of the 1986 sequester requirement. As has been mentioned, the Agency is looking into what other actions can and need to be take to continue the operation of the USGLI, VRI and SDVI programs.

Question: 4. Reprogramming: During the VA budget hearing held on February 6, 1986 before the House Committee on Veterans' Affairs, the VA testified that it would be submitting a reprogramming request to the respective Congressional Appropriations Committees in order to achieve the savings required by the FY 1986 Presidential sequester order.

(a) Please provide, in detail, what the reprogramming request will include and the reasons in support of the request.

(b) What, if any, limitation or restrictions will affect the reprogramming request or a transfer request to be submitted by the Agency?

Answer: (a) We sent, on March 28, 1986, letters to the Appropriations and Veterans Affairs Committees citing adjustments needed to the 4.3% across-the-board reductions to sub-activities in the General Operating Expenses and Burial benefits accounts. In General Operating Expenses there is a need to redistribute funding internally within the Department of Veterans Benefits (DVB) subactivities to minimize the potential of employee furloughs. Specifically, we are proposing the transfer of $2.8 million in ADP funding from the subactivity ADP Systems Management to restore 171 FTEE to the other DVB subactivities. Sequestration resulted in a 431 FTEE loss in DVB. This action would reduce the FTEE loss to 260. The redistribution proposed is as follows:

DVB Subactivity	Requested Change BA ($000)	Requested Change FTEE
Executive Direction	$+ 119	+ 7
Veterans Services	+ 671	+ 32
Compensation, Pension & Education	+1,014	+ 54
Loan Guaranty	+ 525	+ 28
Insurance	+ 142	+ 8
Vocational Rehabilitation & Counseling	+ 177	+ 8
ADP Systems Management	-2,803	...
Office Services	+ 155	+ 34
Total	$ -0-	+171

Also, within GOE General Administration we are proposing to transfer $150,000 to the Board of Veterans Appeals to meet additional payroll needs. This funding will come from the Office of Administration which had generated some savings in supplies and space rental costs.

In the Compensation and Pensions Appropriation we propose a redistribution of $1,315,000 from Pensions to fully cover funding for the following burial benefits:

Program	Amount ($000)
Burial Flags	$ 412
Headstone/Markers	633
Retired Officers	32
Adjusted Service Certificates	1
Mortgage Insurance	204
Special Allowance Dependents	33
Total	$1,315

The impact of the above proposed action will not result, however, in any decrease in pensions payments to veterans. This adjustment can be accomplished because a recent analysis of the pension activity has indicated that excess funds are available to support additional burial benefits funding.

(b) There are no limitations or restrictions affecting the above requests. No changes in overall funding level between appropriations are proposed--just adjustments within the subactivities in both General Operating Expenses and Compensation and Pensions.

QUESTION 5. VA Home Loan Programs:
(a) Please provide a full analysis of the estimates provided for the FY 1986 new direct loan and new loan guaranty activity and the method of computing the sequester baseline amounts which served as the basis for:

(i) the January 15, 1986 joint OMB and CBO report;

(ii) the President's budget estimates which were submitted to Congress on February 5, 1986; and

(iii) the VA's revised estimate of FY 1986 loan originations which was referred to in the VA letter dated February 5, 1986 to Congressman Shelby, Chairman of the House Veterans' Affairs Subcommittee on Housing and Memorial Affairs.

RESPONSE:

(i) The estimate for 1986 guaranteed loan volume ($12,084,543,000), used by OMB as part of the sequestration process along with CBO, was the VA's estimate of loan volume for the 1986 column of the President's 1987 Budget.

(ii) The estimates of 1986 and 1987 loan volume found in the President's budget were originally formulated in May 1985 when the maximum interest rate on home loans was 12.5 percent. During the summer, interest rates declined to 11.5 percent but there was still no sharp increase in appraisal activity or loans closed that would indicate that VA's 1986 estimate was significantly low. Therefore, the VA did not revise the estimate. VA's projection of $12 billion (182,000) loans in 1986 is slightly higher than the 1985 level (178,931 loans) when rates fluctuated between 11.5 percent and 13.5 percent.

(iii) The revised estimate of loan volume of $18.2 billion in 1986, absent the Gramm-Rudman-Hollings limitation is based on first quarter actual activity and what VA expects for the remainder of the year. This estimate considers appraisal requests and loan applications now coming to the VA which are the forerunner to loans closed in the future. VA even expects an upturn over the first and second quarters because of seasonal factors. However, some of the applications which would have come in the spring and summer may have been submitted earlier. Historically, the spring and summer tend to be more active particularly in the purchase of new homes.

QUESTION 5(b)(i): In view of the changed economic situation to which the VA now attributes the need to revise substantially upward, the FY 1986 estimated new loan activity, why was OMB or GAO not notified that the estimate was outdated, prior to the budget submission to Congress, or the issuance of the GAO sequester report or the President's sequester order, in order to revise the FY 1986 activity projections?

(ii) Do you believe that the VA loan activity contained in "VA Loan Guaranty Highlights" for the last quarter of FY 1985 and the first quarter of FY 1986 indicate substantially increased loan activity?

Response:

(i) The level of GI loans closed for May through October was as follows:

Month	Number	Annualized Rate
May	13,693	164,316
June	14,849	178,188
July	17,039	204,468
August	19,363	232,356
September	19,605	235,260
October	16,837	202,044

By mid-November when the October loan volume was known VA's estimate of loan volume for FY 1986 still seemed reasonable. There was a downturn in October when the annualized rate was 11 percent over the FY 1986 estimate of 182,000. Fluctuations in loan volume of this kind are not unusual. It would be difficult for VA to justify redoing the entire Loan Guaranty budget including FTE requirements based on these numbers. The possibility that Gramm-Rudman-Hollings would limit loan volume was not known in VA at this time.

(ii) The data contained in the "VA Loan Guaranty Highlights" is accurate and does indicate that loan volume has been increasing in response to lower interest rates.

QUESTION 5(c): The VA has indicated it will implement, temporarily, three major programmatic changes to the home loan guaranty program including: (1) termination of refinancing; (2) elimination of partial or restored guarantees, and (3) a maximum loan limitation of $90,000 on all new loans. Please provide:

(i) a full analysis on why these options were chosen over other options;

(ii) the estimated savings to be achieved and the assumptions supporting the savings estimates for each of the three program reforms;

(iii) the estimated impact on the loan guaranty program and numbers of veterans and active duty military affected for each of these reforms; and

(iv) details on how these program changes will be implemented and what event(s) will determine or trigger the reduced benefits under the sequester order, particularly with regard to pending applications.

RESPONSE 5 (c) (i-iv): We have revised our position on the selected changes that were to take effect on March 1, 1986. Because of the heavy loan volume so far this fiscal year these changes are no longer practical. Congress has recently enacted legislation increasing the new loan guaranty base amount, prior to sequestration, to $18.2 billion. It is felt that at this revised base level steps can be taken to insure the operation of the program through the fiscal year. The Agency is still considering what actions may be necessary to insure the operation of the program.

QUESTION 5(d): **Please explain whether the implementation of the VA's recommended program changes which would deny refinancing or a partial or restored guarantee to an applicant eligible under current law would be contrary to the requirement of section 252(e) of the "Balanced Budget and Emergency Deficit Control Act of 1985", which prohibits the denial of eligibility for benefits to any person who is or becomes eligible under any provision of law?**

Response 5 (d): As noted in the response to question 5 (c), we have revised our position on the selected changes that were to take effect on March 1, 1986.

QUESTION 5(e): **(i) If the loan ceiling is reached before the end of FY 1986, will the VA stop guaranteeing all loans?**

(ii) Would this action violate section 252(e) of the law, and if so, what alternatives would be available?

Response 5 (e) (i-ii): The President's sequestration order places a limitation on the dollar level of new loan guarantees the VA could grant in 1986. This limitation is legally binding and once the limit was reached the Agency would have to suspend operations. However, Congress has recently passed legislation increasing the new guarantee loan base from $12.1 billion to $18.2 billion. It is felt that at this base level, prior to sequestration, that the Agency can take steps to insure the operation of the program through the fiscal year. The Agency is continuing to look into what steps can and need to be taken to insure the operation of this program.

QUESTION 6. Medical Care:

(a) The February 4, 1986 VA fact sheet states that savings will be achieved by reducing average DM&S employment by 1,306.

  (i) Please provide a detailed analysis on how this will be implemented, by: the classifications of employees affected (physicians, registered nurses, physical therapists, etc.), the distribution by VA medical center, nursing home, domiciliary, outpatient clinic, and vet center, and the program activity (medical beds, alcohol and drug abuse treatment unit, inpatient PTSD unit, etc.). Please include the assumptions underlying the allocations.

  (ii) How many full-time, part-time and temporary employees would be affected?

  (iii) What impact will such a reduction have on direct patient care?

(b) (i) Please provide a detailed analysis, including policy and methodology, by each activity, on how the medical care 1% special rule sequester reductions were determined, including the baseline levels for each activity and how the reductions will be implemented within each activity.

  (ii) Please also include an analysis of how the total obligation sequester amounts were determined for each activity.

  (iii) To what extent were MEDIPP priorities, productivity improvements (resulting from the VA's implementation of the new resource allocation methodology, or affiliation or non-affiliation with a medical school used to determine the number, type, and distribution of the savings?

  (iv) What other factors were taken into account?

  (v) Were the reductions prorated to ensure the equitable distribution of the reductions (i.e., so that no profession, program activity, or medical facility) would absorb a disproportionate share of the reductions? If not, why not? And if not, what other specific efforts were made to promote the equitable distribution of the reductions?

  (vi) What other options were considered besides reductions in FTEE to achieve the required savings?

(c) How will the sequester amount for the 401(C) offsetting collections for the VA hospital activity be implemented?

(d) Please provide an analysis of the total obligation FY 1986 sequester amount for the VA hospital activity, and indicate whether the VA's analysis of the sequester level includes the full amount of the offsetting collections for this activity, or 4.3% of the offsetting collections, and the reasons in support of such determination.

Answer: The appropriation level for Medical care is lowered by $117,557,000 (obligations by $117,878,000) and by an estimated 1,306 FTEE as a result of sequestration pursuant to PL 99-177 (the Balanced Budget and Emergency Deficit Control Act of 1985). In accordance with the law, this sequestration was uniformily distributed across the major Medical care programs and sub-activities.

The activity breakdown showing the amounts in the base that are attributed to administrative and non-administrative expenses for purposes of the provisions of the law, under which certain administrative expenses are subject to a 4.3 percent reduction and non-administrative expenses to a maximum reduction of one percent in 1986, is shown below:

Activity	Non-Admin. Base	Admin. Base	Offset Collect Base	Total Base	Total Oblig. Sequest.
VA Hospitals....	$4,993,994	$476,883	$32,094	$5,502,971	$ 70,767
VA Nursing Homes	383,800	42,070	...	425,870	5,647
VA Domiciliaries	93,000	12,977	...	105,977	1,488
Outpatient Care.	1,657,200	100,024	...	1,757,224	20,873
Misc. Benefits & Services......	330,400	95,163	...	425,563	7,396
Education & Trng.	460,400	24,744	...	485,144	5,668
Contract Hosp...	139,900	1,349	...	141,249	1,457
Comm. Nurs. Homes	278,400	5,674	...	284,074	3,028
State Home Hosp.	2,900	163	...	3,063	36
State Home Nursing Care..........	53,000	581	...	53,581	555
State Home Domiciliaries.	12,200	372	...	12,572	138
CHAMPVA.........	82,500	...	...	82,500	825
TOTAL..........	8,487,694	760,000	32,094	9,279,788	117,878

The activity distribution included in the VA's budget represents a prospective estimate by program of how the 172 VAMCs will utilize their total available resources. The budget distribution by activity does not limit VAMCs from using their own management prerogative in achieving maximum health care per dollar. One management decision may impact one or many activities.

The budget decisions made in order to reduce the $117,878,000 in obligations sequestered are as follows:

	Workload	FTEE	1986 Obligations(000)
Medical Care			
Administration............	...	- 806	$- 23,524
Employment (Non-Ceiling)..	...	- 500	- 5,250
Reduced 1985 Salary Base..	...	...	- 40,000
Telephone Systems.........	...	...	- 14,000
Replacement Equipment.....	...	...	- 9,415
Nonrecurring M&R..........	...	...	- 20,000
Non-VA Workload..........	...	...	- 5,689
Contract Hospital ($1,399)	- 8 census		
Community Nursing ($2,784)	- 118 census		
State Homes ($681)	- 136 census		
CHAMPVA ($825)	- 3 census		
	- 3,000 visits		
Total Reduction Medical Care		-1,306	$-117,878

These reductions, it was felt, would have the least effect on the 172 VAMCs. Minimal employment and workload related reductions were taken and we expect no effect on VA workloads.

The budget provides estimates of the activity distribution and the sequestration is presented in accordance with PL 99-177 guidelines. However, VAMCs provide care and expend resources based on patient care needs and some adjustments maybe needed.

When full year actual data is available the impact of this reduction will be known on such items as classification of employees affected, the full/part-time and temporary status of the employment reduced, the individual sub-activity program changes, etc.

QUESTION 7. General Operating Expenses:

7A. The VA's fact sheet dated February 4, 1986 provides a list of the 4.3% sequester as it was applied to object categories within the GOE account. Please provide a detailed description of how the 4.3% sequester reduction was applied to each object within the account, how each of the percentage reductions were determined for each object, and how the spendout rate affected the reduction percentage.

Response:

7A. The 4.3% sequestration required by P.L. 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985, was applied equally to each program, project, activity and subactivity, as detailed in the budget justification documents submitted to the House and Senate Appropriations Committees, as amended pursuant to P.L. 99-160, the Housing and Urban Development-Independent Agencies Appropriation Act, 1986. The reductions by object were the decision of each department and staff office as to the best way to manage their organization with these reduced resources. A list of base budget authority and the sequestered amount, by activity and subactivity, is attached.

Approximately half ($16.8 million) of the total $32 million required sequestration will be in the payroll area and will require a reduction of 492 FTEE. Of this, the Department of Veterans Benefits (DVB) will lose 431 FTEE and $13.7 million, the Department of Memorial Affairs (DMA) will reduce 13 FTEE and $330,000, and General Administration will lose 48 FTEE and $2.8 million (a reprogramming within DVB subactivities will be proposed to reduce the FTEE impact of an across-the-board reduction of 4.3%).

In the non-payroll areas, expenditures for contractual services will be reduced by $4.3 million, and supplies and equipment purchases will be reduced by $3.1 million and $3.5 million, respectively. For DVB, this will mean $475,000 less for modernization, $474,000 less for payments to state approving agencies for reimbursement of costs incurred in inspecting, approving and supervising education and training programs, and $250,000 less for reporting allowance fees paid to schools for administrative and report preparation costs. Further, purchase of office supplies and operating and maintenance supplies will be reduced by $2.2 million and purchase of replacement office equipment (calculators, telephones, etc.) by $2.0 million.

DMA will reduce $1.6 million by cancelling or postponing maintenance and repair projects at national cemeteries as well as purchases of vehicles and utility and operating equipment.

General Administration will reduce lease and maintenance costs by $1.1 million by reducing the ADP inventory and cancelling maintenance contracts. Other Services will be reduced by $2.2 million by eliminating all contract support for application development, except for VADATS (VA Data Transmission System), and by curtailing background investigations and contract audits by the Inspector General. Also, purchase of supplies and equipment will be reduced by $0.9 million and $0.8 million, respectively.

Finally, travel will be reduced by $1.5 million and printing by $1.7 million in G.O.E. to reach the sequestered total of $32.0 million.

The percentage reduction was determined government-wide based on a comparison of budgetary resources and outlays, excluding legal obligations made in prior years, with the federal deficit. The 4.3% rate was applicable to all non-defense, non-exempt programs.

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PROGRAM, PROJECT, ACTIVITY DETAIL
($000)

Agency: Veterans Administration

Account Title: General Operating Expenses

Account ID code: (29-00-0151-X-1-705-A; 36-0151)

Source: Public Law 99-160 (1986 Appropriation)

Program, project, activity	Budgetary Resources	
	Base	Sequester
1. Department of Veterans Benefits	$490,531,000	$-21,093,000
a) Executive Direction	19,256,000	-828,000
b) Veterans Services	68,791,000	-2,958,000
c) Compensation, Pension, & Education	125,953,000	-5,416,000
d) Loan Guaranty	61,465,000	-2,643,000
e) Insurance	9,093,000	-391,000
f) Vocational Rehabilitation & Counseling	22,697,000	-976,000
g) ADP Systems Management	11,276,000	-485,000
h) Office Services	172,000,000	-7,396,000
2. Department of Memorial Affairs	43,838,000	-1,885,000
3. General Administration	210,495,000	-9,051,000
a) Administration	2,265,000	-97,000
b) Inspector General	19,401,000	-834,000
c) Board of Contract Appeals	771,000	-33,000
d) Board of Veterans Appeals	16,981,000	-730,000
e) General Counsel	27,400,000	-1,178,000
f) Program Analysis & Evaluation	2,723,000	-117,000
g) Budget & Finance (Controller)	18,567,000	-798,000
h) Personnel & Labor Relations	9,642,000	-415,000
i) Equal Opportunity	1,389,000	-60,000
j) ADA/Congressional & Intergovernmental Affairs	1,210,000	-52,000
k) ADA/Public & Consumer Affairs	2,736,000	-118,000
l) ADA/Management	451,000	-19,000
m) ODM&T	78,483,000	-3,375,000
n) Information Management & Statistics	6,181,000	-265,000
o) ADA/Logistics	315,000	-14,000
p) Administration	21,980,000	-946,000
Total	$744,864,000	$-32,029,000

Question 7(b): The VA PPA analysis projects a FTE reduction of 431 (3.3%) for the Department of Veterans' Benefits which it states will require reprogramming because the 431 FTE reduction in 1986 cannot be met without other personnel actions beyond a hiring freeze. How will this FTE reduction be allocated and what assumptions will be used in making the allocation?

Response: The reduction of 431 FTEE for the Department of Veterans Benefits will be reduced to 260, based on a proposed reprogramming from nonpayroll accounts (see response to Question 8(g) below). This reduction in FTEE has been allocated throughout the Department.

QUESTION 7c: Please describe in detail what ADP systems modernization initiatives will be affected by the $.5 million sequester and how the the amount(s) are allocated.

ANSWER: The sequester requires a reduction of $.475 million in the ADP modernization budget. The Agency has chosen to implement the reduction on these two modernization initiatives planned for FY 1986.

DVB allocated $.5 million for contractual services to design an optical disk prototype system. A pilot project is planned to determine the feasibility of using optical disk technology to eliminate the tremendous volume of document storage in claims files and to reduce paperflow within Regional Offices. The sequester reduces the $.5 million allocated for this initiative to $.325 million in FY 1986.

DVB also budgeted $ .3 million in FY 1986 for ADP security systems redesign. Contractual resources will be utilized to evaluate recent developments in security systems architecture to find a more comprehensive and flexible means for maintaining ADP system security. As a result of the sequester, no funding will be available in FY 1986 for this initiative. ADP security redesign will be moved back to the FY 1987 budget.

Question 8: Department of Veterans' Benefits Staffing:

(a) As of January 1, 1986 how many employees are working for the Department of Veterans' Benefits?

(b) (i) Please provide a breakdown showing how many are in field stations and how many are at VACO.

(ii) How many are full time; how many are part time?

(iii) How many are permanent; how many are temporary?

(c) (i) How many DVB employees provide direct service to veterans?

(ii) How many claims examiners do you have now?

(iii) How many individuals in (i) and (ii) will you lose as a result of the sequester order, and what impact will this have on claim processing backlogs?

(d) (i) How many veterans' benefits counselors do you now have?

(ii) How many will you lose as a result of the sequester order?

(iii) What impact will this have on waiting time for the veterans seeking to contact the VA?

(e) (i) How many vocational rehabilitation specialists and counseling psychologists do you have?

(ii) How many will you lose as a result of the sequester order?

(iii) What impact will this have on caseloads and the time a veteran must wait for service?

(f) How many DVB employees did DVB lost to attrition in 1984 and 1985?

(g) What resources can be reprogrammed to provide additional funds for personnel within DVB? What will be the effect on services to veterans as a result of this reprogramming?

(h) What priorities have you established to ensure changes in staff levels have as little effect as possible on service to veterans?

(i) How will you apportion staff reductions between service providers and support and supervision staff?

(j) Have you considered any procedural changes that would increase the amount of time DVB staff can devote to the service of veterans?

Response: (a) The number of employees working for the Department of Veterans Benefits, as of January 1, 1986, was 13,516. The Full Time Equivalent Employment (FTEE) at this time was 13,068 (personnel are expressed in the budget in FTEE).

(b) (i) The total number of employees working in the field and at VACO was 13,122 and 394, respectively. The FTEE was 12,681 for the field and 387 for VACO.

(ii) The number of full time and part time employees was 13,068 and 448, respectively. FTEE figures are not available.

(iii) The number of permanent and temporary employees was 12,665 and 403, respectively. FTEE figures are not available.

(c) (i) As of January 1, 1986, there were 9,275 employees in the Department providing "direct" service to veterans. These include field personnel in the Compensation, Pension and Education, Vocational Rehabilitation and Counseling, Veterans Services, Loan Guaranty, and Insurance programs.

(ii) We consider all adjudication personnel other than our clerical support staff to be functioning as "claims examiners." As of December 31, 1985, there were 3,108 employees operating in the direct development and processing of claims.

(iii) We will lose 326 FTEE in the benefit programs as a result of the sequester order. The Adjudication function will lose a total of 139 FTEE as a result of the sequester order. Each regional office will be impacted differently, depending on their workload and how the loss is spread nationwide. The net result will be a loss in timeliness of claims processing, although that loss cannot be estimated at this time.

(d) (i) As of January 1, 1986, there were 2,017 veterans benefits counselors. We are assuming that the term "veterans benefits counselor" is used generically and is meant to include all of the technical positions in VSD which provide direct service to veterans and their dependents.

(ii) Average employment was reduced by 79 FTEE.

(iii) There is no doubt that the loss of 79 FTEE in Veterans Services Divisions will have an adverse impact on service delivery. This impact will be reflected in a decrease in the timeliness and the quality of service to veterans. Actual change cannot be determined at this time.

(e) (i) The field stations had a November, 1986 allocation of 161 vocational rehabilitation specialists (VRS's) and 277 counseling psychologists.

(ii) Average employment was reduced by 21 FTEE.

(iii) Current vocational rehabilitation specialist (VRS) workload averages about 190 chapter 31 veterans per VRS. If reductions are taken in equal proportions between VRS's and counseling psychologists, the average VRS workload will be 218. Counseling psychologists average about 25 case completions per month. If this rate is maintained, first time appointments for chapter 31 applicants, which now average 79 days from the date of the application is received in the VA to the appointment date, will increase to an average of 86 days.

(f) The Department lost 2,796 and 2,867 employees in 1984 and 1985, respectively. Many of these losses were lower graded positions or represented more than one employee in the same position during the fiscal year. As a result, the savings from these losses is difficult to identify. The Department is developing informaton on these and other factors to provide an adequate analysis of the impact of the current freeze on employment.

(g) Funds totaling $3.5 million are being considered for reprogramming to reduce the impact of the sequester order on DVB employment. The nonpayroll reductions by object class are $.2 million in travel, $.7 million in rents, communications and utilities, and $2.8 million in other services. These reductions will be offset by an increase of $3.5 million in personal services and $.2 million in printing and reproduction. The effect of this reprogramming on service to veterans will be less of a reduction in services provided. An additional 171 FTEE will be available for the field to provide direct service to veterans.

(h) As noted above, the Department has proposed a reprogramming to limit the impact of the sequester order on employment. As a result, reductions in nonpayroll areas have been taken above the 4.3 percent level.

These include:

Item	% Reduction
Travel	15.1
Printing and Reproduction	25.3
Supplies	39.5
Equipment	28.0
Other Services	10.6

Field personnel involved in direct service to veterans have been afforded the highest priority.

(i) The Department of Veterans Benefits has issued to each field station and VACO a revised FTEE staffing level for 1986. Station directors or other Department officials will determine the distribution of that total by service, support and supervision staff.

(j) Yes. All station directors and VACO officials have been encouraged to review existing procedures in order to identify potential areas for increased service for veterans.

QUESTION 9. Department of Veterans' Benefits—Benefit Payments:

(a)(i) Please explain how the VA proposes to apply the sequestration order to each of the following programs:

- Vietnam Era GI Bill
- Post Vietnam Education Benefit Program (VEAP)
- Burial and Plot Allowances
- Vocational Rehabilitation

RESPONSE:

Vietnam Era GI Bill - Educational assistance allowances will be reduced 8.7 percent for all payments obligated during the period March 1 - September 30, 1986.

Post Vietnam Education Benefit Program (VEAP) - This program is exempt from the sequestration order because outlays are funded by offsetting collections from other Federal agencies (and prior year balances) and are not subject to VA sequestration.

Burial and Plot Allowances - There has been a revision in the methodology used to determine the reductions for this program. Instead of reducing benefits by 10%, as has been earlier announced, the reduction to burial allowances, burial plots, service-connected allowance, and headstone allowance will be 7.75%. The Agency will request reprogramming authority to the Burial Benefits activity from the Pensions activity in order to fully fund the "in kind" benefits (primarily acquired through contracts). These "in kind" items include burial flags, headstone/markers and other similar benefits not amenable to sequestration. These items were previously contracted for in 1986.

Vocational Rehabilitation - Payments on behalf of these veterans for books, supplies, tuitions, fees, and equipment, which on an average will be $1,541 for 1986, will not be reduced because of the difficulty in monitoring a 4.3 percent reduction in a payment that covers actual cost. Therefore, the sequester for the vocational rehabilitation program will be achieved by reducing the subsistence allowances by 13.1 percent for all payments obligated during the period March 1 and September 30, 1986. The average percent reduction in total benefits per veteran during this period will be 7.7 percent.

Question 9(a)(ii) Please explain why the VEAP program is treated differently from other programs in the fiscal year 1986 sequester order?

RESPONSE: Outlays of the VEAP program consist of the participant's own money either in the form of disenrollments or training payments and payments made by the Department of Defense for matching benefits or bonus "kickers". The federal portion of this program are funded in appropriations provided to DOD. The DOD then transfers these funds to the VA for program administration. The transfers of these funds from DOD are not subject to VA sequestration.

QUESTION 9(a)(iii): If a sequester is necessary in FY 1987 how would **the VEAP program be treated?**

RESPONSE: The Department of Defense exempted the budget authority to fund VEAP transfers for veterans' matching payments from sequestration under the special rules applying only to 1986. If a sequester were necessary in 1987, DOD would have less flexibility than provided in 1986. However, it is understood that DOD will reprogram resources to fully fund the transfer of budget authority to support the program in 1987.

QUESTION 9(b): Where the amount of benefits is to be reduced, how was the amount of reduction computed?

RESPONSE: The methodology used to determine the reduction is basically the same. First, it was necessary to estimate actual obligations through February 1986. This estimate was taken from the end of year total to determine the estimated expenditures from March 1986 through September 1986. In the case of the Vietnam-era GI Bill the sequestration dollar amount was divided by the March - September 1986 estimate to determine the percentage reduction.

The computation of the reduction to be made in the payment of burial allowances, burial plots, service connected allowance and headstone allowance was the same as discussed in the preceeding paragraph. It is estimated that a 7.75% reduction in the payments for these items will achieve the reduction made to these activities in the sequestration process. However, the payment for burial flags, headstone/markers, mortgage allowance presented a different problem. These payments for "in kind" benefits do not lend themselves to benefit reduction. These items are basically administrered on a contractual basis and would be difficult to alter. Because of these considerations, a reprogramming from the Pensions program will be requested to fully fund these in kind benefits.

The methodology used to determine the vocational rehabilitation savings was similar to burial benefits. It was determined that payments for books, supplies, tuition, fees and equipment would not be reduced. The sequestered savings amount was applied to the estimated amount to be paid in allowances between March 1986 and September 1986. This is why the total program reduction of 7.7 percent for the March - September 1986, resulted in a 13.1 percent reduction to the subsistence rates during the sequestered period.

QUESTION 9(c): **Please provide a written opinion from the VA General Counsel concerning your proposed action indicating whether it is required or permitted by the "Balanced Budget and Emergency Deficit Control Act of 1985?" What authority are you basing your actions upon?**

Response 9(c): We view the Gramm-Rudman-Hollings as establishing reduced funding estimates for the affected VA benefit progrgams. PL 99-177 sets forth three additional limitations: first, that reductions will be applied equally to each affected program, project, and activity (PPA) and in 1986 to each subactivity; second, that none of the aforementioned PPA's shall be eliminated; and third, that no individual shall be denied benefit eligibility as a result of such reductions. Operating within the foregoing framework, we rely on the program authority set forth in Title 38 for the administration of the affected VA functions.

QUESTION 10. Automated Data Processing:

Under the required 4.3% reduction required for FY 1986 under Gramm/Rudman, how will the VA's ADP functions --- in DM&S, DVB, ODM&T, and Central Office general administrative ADP requirements -- be affected? Specifically, in what areas will FTEE be reduced; in what areas will hardware, software or contractual resources be reduced; what systems will be delayed (for example, will the implementation of the WANG office automation contract, already in progress, be affected)?

Response:

DM&S estimates a reduction of $1.914 M in FY 1986 medical care ADP funds due to the 4.3% reduction required under Gramm/Rudman. This estimated reduction includes 66 FTEE ($1.615 M) and $.299 M in operating supplies. The reductions were taken from other than DHCP related areas and will therefore have no significant impact on the progress of the DHCP in FY 1986.

A reduction of $.150 M was taken from the FY 1986 MAMOE ADP funds. This reduction will also have no significant impact on the DHCP. It may, however, have some effect on the implementation of the VACO WANG office automation system within DM&S in FY 1986.

Contractual services for two modernization initiatives included in DVB's FY 1986 budget are affected by the 4.3% Gramm/Rudman reductions. Funds allocated for Optical Disk Prototype Design are reduced from $.5 M to $.325 M. The $.3 M budgeted for ADP Security System Redesign is moved back in its entirety to FY 1987.

No reduction in the 25 FTEE allocated to ADP Systems Management is planned. Implementation of the WANG Office Automation System within DVB is not impacted by Gramm/Rudman reductions.

ODM&T did not reduce any FTEE as a result of Gramm/Rudman.

The plans to continue enhancement of the Austin DPC configuration by increasing memory, disk capacity and installing programmer workstations in FY 1986 have been deferred. Further, plans to install an electronic printing system at Philadelphia; and additional office automation equipment at Austin, Hines, Philadelphia and Central Office in FY 1986 have also been deferred. These deferred enhancements will cause delays in ODM&T efforts to provide greater end-user access to the Agency files and data bases through timesharing.

Funds for contract support for systems analysis and programming have been deleted from our FY 1986 plans except for those associated with VADATS and those required to complete some task orders which were begun in FY 1985. Therefore, an extended time-frame will be experienced in the development of computer systems for PAID Redesign, Department of Memorial Affairs Systems, Paperwork Management and Regulation System and Automated Budget Execution System. ODM&T in-house resources will continue to be devoted to these systems, but plans had been based on the majority of the design and programming work being performed through vendor contracts.

Essentially, this level of funding and staffing will permit ODM&T to maintain the current services level of operational support which was in effect in September 1985. There are no provisions for additional equipment or contractor support; thus, the Agency's modernization program for the corporate data processing environment will be suspended until such time as funding again becomes available.

In summary, to make the 4.3% reduction of $3.375 M from ODM&T's FY 1986 budget level, we reduced funding for operating supplies, magnetic tape, postage, overtime, travel, printing and reproduction, ADP hardware lease/maintenance and contract support.

In Central Office, general administration ADP represents a small portion of each staff office's total budget. Office automation plans will be maintained as much as possible to meet the efficiencies which are being planned in 1987 and beyond. Nonetheless, delays in the procurements from the WANG contract are anticipated. The estimate on the delay in equipment purchases cannot be made until the payroll requirements are determined. Emphasis on the avoidance of a furlough will delay some procurements for the next few months. Later in the year, procurements may be processed if attrition patterns occur as expected.

VA MEDICAL CARE PROGRAMS

Question: 1. The budget documents assume the implementation of a means test, a reduction of almost 9,000 medical care staff, and a corresponding reduction in inpatient and outpatient workloads.

a. Please provide a policy analysis and description of the methodology used to determine the workload reductions.

Answer: Because the VA medical care program is discretionary (i.e. patients are treated within available resources), savings are proposed in the FY 87 budget request for treating fewer non-service-connected veterans who have a low eligibility priority.

Question: 1h. Please provide information on the numbers of veterans who will be treated in VA hospitals, nursing homes, domiciliary facilities, outpatient clinics, and vet centers and what percentage of these are service-connected veterans, "special category" veterans, and non-service-connected veterans?

Answer: The table below shows the approximate number of patients who were treated in VA facilities during FY 1985 and the percentage who were service-connected and non-service-connected veterans.

VA Inpatient	Total Number	Percent SC	Percent NSC
Hospitals	1,301,000	30.1	69.9
Nursing Homes	20,000	24.5	75.5
Domiciliaries	13,000	9.8	90.2
VA Outpatient	17,789,000	47.0	53.0
Vet Centers	Data unavailable	-	-
Special category veterans with data available			
Hospital			
WWI	31,000	16.9	83.1
WWII	544,000	29.0	71.0
Pensioners	173,000	-	100.0

Neither the implementation of a means test nor the reduction in medical care staff are proposed to have any effect on the number of veterans treated in nursing homes and domiciliaries. Additionally the 1987 budget proposals will not affect the number of service-connected veterans and "special category" veterans treated. However, there will be a reduction of 40,000 non-service-connected non-pensioned treated in VA hospitals and about 200,000 non-service connected and non-pensioned would not receive outpatient care.

Question: 2.

In response to a question (Question 38) pertaining to horizontal and vertical reductions which I asked you to submit for the record following the Committee's February 20, 1985, hearing on the VA's fiscal year 1986 budget, you stated:

> The following two paragraphs provide an explanation of "vertical" and "horizontal reductions". In either case this represents a reduction of services provided.
>
> A vertical reduction is defined as the discontinuation of a program or service or the closing of a facility. This could involve the elimination of a program or service nationwide, i.e., the domiciliary facility program or the closing of an entire facility. The advantages of this kind of a reduction are that while a program may be eliminated or a facility closed, the remainder of the system maintains its vitality, and the quality or integrity of the health care provided is not compromised. Achievable savings would vary tremendously based on what service, program or facility is eliminated.
>
> A horizontal reduction can be defined as an across-the-board reduction. A ten percent reduction, for instance, could be applied across the board to all facilities. That is, each facility would receive an employment and funding level that reflects ten percent less resources.
>
> The advantage of this approach is that everybody shares equally in the cut and the full range of services can still be provided. The disadvantage, is that across the board reductions could ultimately impact the quality of patient care, tending to strangle the system as a whole.
>
> The utilization and impact of each of these methods varies. One consideration is the size of the resource reduction or absorption. Small reductions can be made horizontally (or across the board) without impacting the quality of health care. On the other hand, if substantial reductions are required, then the closing of facilities or elimination of programs (vertical reductions) must be considered. In either case, the decision process involves a determination of how to achieve the reduction and still provide quality health care to the greatest number of eligible veterans.

I am concerned that a reduction of $504 million and 8,927 FTEE in the medical care account will "strangle the system". Please provide the following information:

a. What vertical reductions could you implement to achieve $504 million in savings with a minimal impact on FTEE and workload reductions?

Answer: We have no plans for the complete elimination of VA medical centers as a means to accomplish vertical reductions. In the absence of complete closures, the major strategy for the Agency to achieve reductions will be consolidations of existing medical programs into major tertiary medical centers with commensurate reductions in other VA medical centers. The economic efficiencies derived by such consolidations in terms of increased use of scarce capital and personnel resources will result in actual savings with minimal impact on overall service availability. Such consolidations could involve, for example, movement of highly specialized medical programs such as cardiac surgery into major tertiary medical centers. Other consolidations involve movement of outpatient and extended/nursing home care activities into select VA medical centers with commensurate reductions in more expensive acute medical center beds. Examples of this kind of consolidation exist at VA medical centers in Livermore, California, Batavia, New York, and Miles City, Montana where acute medical center capabilities have been, or are proposed to be, reduced in favor of extended/nursing home care. An example of consolidating in favor of outpatient care is a proposal to convert the Walla Walla, Washington VA Medical Center into a comprehensive outpatient clinic. Guidance for the upcoming MEDIPP planning cycle calls for extensive Medical District reviews to identify potential consolidations in order to permit the Agency to respond as necessary to reductions in the operating budget.

Question: 2 b. Please provide a list of facilities and/or programs you would close or eliminate to achieve these savings.

Answer: Following are vertical reductions approved for further planning consideration as a result of the 1982-1984 MEDIPP cycles:

Consolidate Satellite Outpatient Clinic - Brooklyn, NY
Consolidate Satellite Outpatient Clinic - New York, NY
Consolidate Satellite Outpatient Clinic - E. Orange, NJ
Close Rehabilitation Medicine Bed Section - Batavia, NY
Close Psychiatry Bed Section - Poplar Bluff, MO
Close Psychiatry Bed Section - Livermore, CA
Close Surgery Bed Section - Batavia, NY
Close Surgery Bed Section - Bonham, NY
Close Surgery Bed Section - Livermore, CA
Convert mission of VAMC Livermore from Acute Care to
  Model Long Term Care

Other vertical reductions, such as the VAMC Miles City surgical service closure, are currently in the review process as a result of medical district analyses associated with the 1985 MEDIPP Implementation planning cycle.

Question: 2c. Please provide an analysis of the policy assumptions and a description of the methodology used and the criteria applied to arrive at this list.

Answer: The foremost assumption in dealing with reductions in in the medical care budget is that medical districts will conduct mission analyses in order to yield proposals for vertical changes in facilities, programs, and subprograms. This may result in consolidation of programs, mission changes for medical centers, or outright elimination of programs. The methodology used to determine reductions is and will continue to be the MEDIPP system. Within MEDIPP, planners will necessarily incorporate actual medical center performances, expected veteran population, and demand projections to arrive at appropriate changes. Given reductions of the magnitude of $504 million and 8,927 FTEE, other management intervention over and above approved MEDIPP actions, such as those based on resource allocation methodologies, will also likely be necessary to achieve mandated budget reductions, and will be decided by VACO.

Question: 3. There has been some discussion of the pros and cons of an "enrollment system" for VA medical care beneficiaries. Please define this term, provide several examples of this kind of system, and state the advantages and disadvantages of an enrollment system in terms of access to care, quality of care, cost of care, and health care services management and delivery, and any other factors you consider appropriate.

Answer: Our concept of "enrollment"--which we have termed the "VA Health Care Plan"--is still enduring.... However, as we view it at this time it would focus on reorganizing the delivery and management of care to veterans along two primary fronts: develop an overall VA health benefits "package," containing defined services, provided over a specific duration, to a known population of "enrollees;" and, to manage enrollments similarly to the style of capitation approaches proven successful among Health Maintenance Organizations in the private sector. Attendant to a change of this magnitude is a strengthening of our quality assurance and utilization review programs, a major reorganization of the traditional Central Office and Regional management components, and establishment of specific goal-achieving clinical and administrative management behaviors by VA Medical Centers.

As anticipated in the Chief Medical Director's letter to you on July 12, 1985, the possibility of VA establishing such a revolutionary management mechanism to replace the current structures is dependent of broad-based discussions and consultations with the Congress, national veterans' organizations, the Office of Management and Budget and other organizations and interested parties. To pursue this idea will require considerably more development and study. In that context, it is difficult to respond to your specific queries. We would look to enhancements of quality, improvement of access-to-care and equity of resource distribution as the preeminent goals. Certainly, cost containment-by definition--would need to be a goal.

Ouestion: 4. Please provide a list by program and resources (including dollars and FTEE) of the MEDIPP initiatives that were not included in the fiscal year 1987 President's budget.

Answer: In the Department of Medicine and Surgery, Medical District Initiated Program Planning (MEDIPP) identifies programs to meet the future medical care needs of veterans. In the 1984 MEDIPP cycle the planning horizon was 1995. The program needs projected are not necessarily met by new initiatives, in fact, they may be met by a shift in existing programs. Where there is a shortfall, new initiatives are proposed. During the 1987 budget preparation the Department of Medicine and Surgery considered the attached list of new activities.

INITIAL DM&S PROPOSALS FOR FY 1987	FTEE	DOLLARS (000)
Outpatient workload increase in 1987 630,000 visits	1,046	57,293
Inpatient workload increase in 1987 9,763 patients treated	1,650	62,220
Community Nursing Home Care in 1987 1,414 census	0	36,917
Additional GRECC's in 1987 3 new	36	4,281
Additional HBHC programs in 1987 7 new	41	1,830
Additional ADHC programs in 1987 8 VA 10 contract	83	7,140
Enhance GEU staffing in 1987 at 17 sites	34	2,344
Enhance Cardiac Surgery programs at 5 sites	120	2,778

Question: 5. Please provide a breakdown, by provision, of the resources (including dollars and FTEE) that were allocated in fiscal year 1986 and that will be allocated in fiscal year 1987 to implement Public Law 99-166, the Veterans' Administration Health Care Amendments of 1985.

Answer: The total estimated costs of the provisions of PL 99-166 are $100,348,000 and 77 FTEE in 1986 and $97,120,000 and 150 FTEE in 1987. Of these amounts, $85,516,000 for Alcohol and Drug contracts, contract care for Puerto Rico, and eligibility of Agent Orange and Radiation exposed veterans is already in the Medical care base and is allocated to VAMC's. There is no additional funding in 1986 or 1987 to fund the additional provisions of this law (VVRC Pilot; Chiropractic Pilot; Quality Assurance; and, Operational and Construction Plan). The Puerto Rican provisions of the law did, however, free up $1.7 million in 1986 and $5.8 million in 1987 which has been applied towards other Contract hospital requirements. At this time, no plans have been approved or put in place to reduce other medical care components to free up to $14,832,000 and 77 FTEE required in 1986 or the $15,646,000 and 150 FTEE required in 1987, although those issues are under consideration. We clearly would be stressed by these mandates, but do plan at least one pilot VVRC.

Question: 6. During fiscal year 1985, 42 of your hospitals had occupancy rates of less than 70 percent. The worst case was the hospital in Miles City, Montana where the occupancy rate was about 45 percent. Many of the hospitals have had these low rates for years.

a. What occupancy rates do you expect your hospitals to achieve? How many actually achieve these rates?

Answer: Planning for future bed requirements under the MEDIPP process utilizes an overall facility occupancy rate of approximately 87 percent, which represents a combination of ideal occupancy rates of 85% for acute and 95% for extended care bed sections. In 1984, 18 facilities achieved this rate of occupancy or greater. In our planning efforts to achieve the ideal facility occupancy rate, 34 additional medical centers achieved fiscal year 1985 occupancy rates within the range of 80 to 86.9 percent. The Department has made every attempt to maintain the 90,000 bed floor mandated by Congress. This has manifested itself by low occupancy rates at some medical centers. Occupancy rates per se, however, are becoming less insightful as measurements of efficiency. This is true in the VA as it is in the private sector, where the national average is approaching 65%. Our internal,"prospective" resource allocation system is providing a direct incentive to facilities to treat patients in the most efficient manner possible which tends to lower the reported occupancy rates. In the future we may as a result identify a need to adjust our goals on occupancy or to reduce the total number of acute care beds we operate.

Question: 6b. What actions have you taken in the past year to improve the occupancy rates (either by closing units, converting beds, or attracting more patients)?

Answer: Actions which include the closure or down-sizing of units and the conversion of beds from one bed service to another are under consideration throughout planning under MEDIPP.

Question: 6c. What actions do you plan to take during fiscal year 1987?

Answer: Implementation Plans for bringing to fruition the proposals resulting from the planning efforts of Medical Districts and Regions are presently under consideration for action. These plans reflect proposals for realignment of beds and associated resources towards achieving care to veterans in the most efficient and effective manner. These plans, and those in subsequent years, will express increased attention to the analysis of facility missions and the tailoring of health care services to the identified patient populations.

Question: 6 d. In how many of the hospitals with extremely low occupancy rates do you plan to convert hospital beds to nursing home care beds?

Answer: Implementation Plans currently under review identify proposals to convert hospital beds to nursing home care beds. Proposals involving such conversion represent the efforts of greater emphasis on mission analysis to address need. There are six proposals in this area involving approximately 350 beds. Such conversions to nursing home care beds are done where there is a clear need for nursing home beds and where there are available hospital beds to convert.

Question: 7. Your medical care budget shows no expected decrease in the length of stay experienced in VA hospitals between fiscal years 1986 and 1987. GAO reported in August 1985 that about 20 percent of the days of care at seven major VA hospitals could have been avoided by better patient management practices. GAO recommended that you improve your hospitals' utilization reviews and hold your managers more accountable.

a. What have you done to implement GAO's recommendations?

Answer: With regard to the concept of improvements in hospitals' utilization reviews (UR), several points can be emphasized.

In 1985, an Office of Quality Assurance Newsletter was published which addressed various aspects of a comprehensive UR management program, including medical center policy, staff responsibilities, methods, UR activities, data uses, periodic evaluation, and confidentiality.

UR is also receiving increased emphasis in the VA Systematic External Review Program. Part of the comprehensive survey is devoted to an analysis of a medical center's UR plan, responsibilities, appropriateness of reviews, coordination with other related functions, documentation, validity of criteria, and action and follow-up.

In March 1986, the DM&S will initiate a UR Management Training Program. This program to be accomplished throughout 1986, will emphasize UR processes and requirements and the development of data bases to monitor and evaluate the quality of care and efficient use of resources. Attendees will include medical center UR coordinators and select service chiefs.

VA Surgical Service recently completed a circular on preadmission surgical screening which should have a positive impact on length of stay.

A new report from the Patient Treatment File (PTF) has been developed. This report shows the number of complete Master Records in the PTF. The report is generated quarterly, is cumulative and is sent to each medical center. The report lists Master Records in the file in discharge date order with patient name, social security number, date of admission, and length of stay. This report gives medical centers a tool to monitor the length of stay for individual patients with the capability for going back to specific records for review. This report has now completed two cycles. The report is PTF report 419.

Question: 7(b) Do you believe lengths of stay are as low as can be expected? If no, why do you predict no further reduction in fiscal year 1987?

Answer: Consistent with our goal of fostering improvements in the clinical management of care and with concerns over cost-consciousness, we believe that lengths of stay can be, and will be, reduced on average over time in the future. Certainly, this has been our experience in the past 10-15 years. Although we are projecting reduced LOS for each type of bed section, we have not projected a reduction in total national average length of stay from 1986 estimate to 1987. This occurs primarily because of 1) the increased care expected in the hospital extended care programs, 2) combined with reductions in numbers of patients treated in acute Medicine, Surgery and Psychiatry bed sections. As can be observed from our budget submission, episodes of care and lengths of stay in acute Medicine, Surgery and Psychiatry are continuing their expected declines, consistent with changes occurring in practice patterns of all American medical care.

Question: 7c. How many more inpatients could you treat with the funds you are requesting by lowering your average length of stay by 0.5 days?

Answer: In responding to the GAO report, we cautioned against quick conclusions in this respect, and we would caution the Committee not to rush to a similar judgement. Many of our hospitalized patients when ready for discharge could be cared for in other settings than hospital beds, but we believe in many of those instances, the alternatives are not yet fully developed. The MEDIPP process is addressing these needs, as is the VA's quality assurance program. However, availability of broad-based services at the local level is a major challenge which will require time to resolve. However, the end point cannot be the "dumping" of poor and elderly patients to unacceptable care alternatives.

Question: 8. Your budget calls for major realignment and conversion of hospital beds to nursing home care beds. You indicate that 59 excess hospital beds will be converted during fiscal year 1987.

(a) At which medical centers will these beds be converted? How were they selected? How many other hospital beds meet the same criteria and can be considered as candidates for conversion?

Answer: At VAMC Buffalo, 34 hospital beds are to be converted to NHC beds and at Batavia, 25 beds are to be converted. The conversion to NHC beds is taking place at these Medical Centers because the conversion is programmatically and demographically justified. All conversions will be based on the following factors: (1) confirmation, through the MEDIPP process, that potential convertible beds are available and located where NHC beds are needed and (2) the availability of resources to convert hospital beds to a more non-institutional, nursing home care environment, including necessary space to accommodate special NHC program requirements. Presently over 1400 beds have been identifed as potential candidates for conversion.

Question: (b) Your minor construction budget indicates you expect to spend $4 million for these conversions. What costs are involved in the conversion? Why can't an acute bed unit be redesignated as a nursing home care unit?

Answer: Acute care bed units can in fact be redesignated as nursing home care units, but for these units to be consistent with present criteria and incorporate current program policies, they will require renovation. This renovation involves de-institutionalizing the environment wherever possible. This de-institutionalization includes necessary space to accommodate special NHCU program requirements, including an increase in patient room size and improvements in patient bathrooms, patient lounges and recreation space. For the complete renovation of a ward to accommodate these changes, costs approximate $23,000 per bed. In a number of cases, staff for these beds have been previously re-directed to areas of increased intensity of care, thus, to make these beds available, additional staffing must be provided.

Question: 9. Several VA hospitals have small surgical units which peform very few surgical procedures annually. For example, 27 of your hospitals have surgical units with less than 50 beds. In an audit report on the VA hospital in Miles City, Montana the Inspector General reported that, on the average, the two full-time surgeons together performed fewer than one major procedure a week and only about one minor procedure per workday.

(a) Do you think veterans undergoing surgery in the Miles City VA hospital or other VA hospitals with small surgery units receive an adequate quality of care?

Answer: We think that the quality of surgical care at Miles City is very adequate. The reason for consideration of closure of the surgical unit at Miles City is for cost-efficiency's sake. It is a location where alternative care is available. We think the quality of care in other VA hospitals with small surgical units is adequate, but, when considering cost efficiency and higher levels of quality, closure is a consideration where adequate alternatives to surgical care are available.

Question: (b) Is there a minimum size for surgical units (in terms of numbers of procedures performed) to ensure that the surgical team (surgeons, anesthesiologists, nurses, etc) are able to maintain an acceptable level of proficiency?

Answer: Each surgical unit is evaluated individually based on patient treatment outcomes as required by JCAH and other monitoring groups, and in consideration of the complexity of surgery being performed at that location. We do limit the scope of surgery at such locations dependent upon the credentials of the staff and the availability of support personnel and require, for example, that tertiary type surgery be referred to a tertiary hospital. No minimum workload standards have been identified either by professional organizations or by the Veterans Administration.

Question: (c) What specific actions have you taken at hospitals with small surgical units to assure that patients are receiving quality care?

Answer: Surgical care at all VAMCs, including those hospitals with small surgical units, is monitored and assessed routinely to assure quality care. This monitoring is conducted locally by each medical center's quality assurance program, in conformance with requirements of the Joint Commission on Accreditation of Hospitals and VA policies. In addition, reports of surgical morbidity/mortality from each facility are reviewed in VA Central Office. DM&S is planning to add three quality assurance monitoring applications over the next twelve months which will significantly enhance the capability of our Quality Assurance System.

Pursuant to Section 204(a) of Public Law 99-166, we will begin reviewing outcomes of care associated with surgical procedures performed at VA hospitals, including those with small surgical units. The findings of this year's review will be evaluated and reported to Congress next Spring. The review of surgical mortality this year will also be under the auspices of the Medical District Peer Review Organizations (MEDIPROs) to identify and assess potential problems at hospitals performing surgery.

In addition, we are planning to develop the concept of occurrence (or generic) screening, using general outcome screening criteria, as a method by which VA medical centers can improve their monitoring of surgical care. When fully implemented, occurrence screening should provide DM&S with more accurate and timely information for quality of care monitoring purposes.

Question: (d) What specific actions do you plan to take (such as eliminating small surgical units)?

Answer: Through the MEDIPP process, small surgical units are being reviewed for cost efficiency. As a result of the 1985 Medical District Initiated Program Planning Implementation Plan, one such proposal was made to eliminate inpatient surgery in favor of an ambulatory surgery program at Miles City. This proposal is currently under review and a decision is expected in April.

Question: 10. Previously, SERP medical facility reviews were conducted by teams made up of health care and administrative personnel from other medical facilities and selected by the Office of Quality Assurance. Teamleaders from the Office directed the reviews. Recently the teamleaders were placed under the seven VA medical regions, reporting to the Regional Directors.

a. Are the regions responsible for funding the SERP reviews?

Answer: Yes.

Question: b. If so, has each region requested the funds needed to conduct the scheduled SERP reviews?

Answer: Yes.

Question: c. How can the VA assure an independent, objective review of the quality of care at each facility if each region is reviewing only those facilities within its boundaries?

Answer: This will be assured through the team selection process as well as the survey process. Team members will continue to be drawn from outside the facility, and outside the district in which the facility is located. The survey process will rely on a systematized process and criteria, the development of which will be coordinated through the Office of Quality Assurance and VACO. This will ensure the survey process is independent and objective.

Question: d. How will VA conduct oversight of the SERP process?

Answer: A more formalized oversight mechanism for the SERP process is currently being developed. Under consideration is an advisory review board consisting of VA Central Office and field officials. This board would function as a subcommittee of a larger quality assurance committee to ensure that SERP process oversight is effectively integrated with many other extant quality assurance functions.

Question: 11. A recent GAO report (GAO/HRD-85-57) stated that VA had not achieved its goal of conducting 60 Systematic External Review Program (SERP) facility reviews annually since fiscal year 1977, averaging about 44 reviews each year. These reviews involve week-long evaluations of the quality of care and the quality assurance programs at VA medical centers.

a. How many reviews are scheduled for fiscal year 1987?

Answer: 70.

Question: b. Will the funds requested be sufficient to review all of the scheduled facilities?

Answer: The SERP survey process is currently under revision, and the cost of the program is dependent on the result of those revisions. Funds will be provided to do all necessary SERP surveys. Precise determination of the budget implications cannot be forecasted until the revisions near completion. It is anticipated the revised approach will be implemented in August of 1986.

Question: c. Will the Office of Quality Assurance continue to fund these SERP reviews?

Answer: No. Funding will be provided through the Director for Operations and the Regional Directors within available funds.

Question: d. If so, how much is in the budget request for the Office of Quality Assurance?

Answer: Operations, which presently has responsibility for SERP visits, has approximately $350,000 earmarked for this purpose.

Question: 12. Please provide information concerning the status of the prosthetics reorganization (proposed on February 1, 1985).

a. What, if any, changes in the reorganization have been or will be implemented as compared to that proposed in the February 1, 1985, plan?

Answer: The basic reorganization, as proposed in the February 1, 1985, plan, has not changed. As was more fully explained in the Acting Administrator's letter of February 14, 1986, to the Chairman, Committee on Veterans' Affairs, the Prosthetics Assessment and Information Center, the Rehabilitation Research and Development Evaluation Unit, and the Office of Technology Transfer will be colocated in Baltimore, Maryland. A survey failed to identify suitable space in proximity to the VA Medical Center, Washington, D. C., at a reasonable price, or which could be made available within a reasonable period of time. Suitable space was located at 103 South Gay Street in Baltimore, and the agency has negotiated an agreement with the General Services Administration to lease 30,000-plus square feet.

Question: b. Please provide a description of the construction resources to be allocated, and a prospectus describing the construction plans for the proposed Prosthetics Assessment and Information Center (PAIC).

Answer: The VA does not have any construction funding resources allocated for the proposed Prosthetics Assessment and Information Center (PAIC). Since the PAIC will be located in leased space, construction funding is not required.

Question: 13. A July 1985 report, "Care of the Terminally Ill", stated that the hospice concept is generally incorporated into the VA medical centers' approach to care. However, on page A-13 of the report, you state that 97 of the 123 responses reported the use of "usual and customary care" and only 26 of the 123 responses reported the use of a specific hospice program. Please explain the inconsistency between the two statements.

Answer: The hospice concept of care is incorporated into the care of the terminal patient at all VA medical centers to some extent. Ninety-seven (97) facilities provide such care to patients on primarily medical services not designated specifically for hospice care but such facilities usually or always meet the following six hospice approaches to care: use of an interdisciplinary team to assess, plan and provide care; maintain the terminal patient at home as long as possible; assure the continuity and coordination of inpatient and home care services; emphasize the management of pain, depression and other discomforts; consider the patient and family as the unit of care; and provide psychosocial counseling to both the patient and family. Twenty-six (26) facilities categorize their approach to care as "hospice care"; 15 designate specific beds for hospice care and 11 have established a hospice consultation team without specifically designated beds for hospice care.

Question: 14. As a provision of Public Law 98-528, the Veterans Health-Care Amendments of 1984, the Congress authorized you to provide special pay incentives for those Veterans' Administration psychologists who obtained their board certification. This provision was modeled after that currently in effect for board certified physicians. The general consensus being that, as with their medical colleagues, this incentive would encourage the highest possible quality of mental health care to be provided to our nation's veterans. It is the Committee's understanding that this provision of the law has not yet been implemented, even though it has been raised on numerous occasions by both myself and the ranking minority member of the Committee. Is this the case, and, if so, why? Does the VA have any plans to implement this provision of the law?

Answer: Public Law 98-528 authorizes the Administrator to use certain discretionary personnel authorities for clinical or counseling psychologists in the Veterans Administration who hold diplomas or diplomats in psychology from an accrediting authority approved by the Administrator.

This provision is not modeled after that currently in effect for board certified physicians. Instead, this provision for board certified psychologists provides essentially the same authorities as are in effect for certified or registered respiratory therapists, licensed physical therapists and licensed practical or vocational nurses in the VA. There is no statutory provision for special pay incentives for board certified psychologists.

Before the Chief Medical Director can offer a recommendation we must assess the clinical and personnel implications as well as the cost effectivness of the use of the discretionary personnel authorities authorized by this statutory provision.

To that end, we have taken the following steps:

(1) The Association of VA Chiefs of Psychology has recently provided requested information.

(2) The American Board of Professional Psychology has provided requested information detailing the specifics of their certification process.

(3) Field facilities have been surveyed for detailed data on numbers of board certified psychologists, etc.

Information and data obtained from these three sources will be used to develop a recommendation for the Chief Medical Director's consideration and ultimate action by the Administrator.

Question: 15. For fiscal year 1987 you are asking for $42.4 million to support the construction of state extended care facilities. You indicate that this will support 4 projects producing 396 extended care beds and 12 non-bed producing projects.

a. Where are the bed-producing projects located? To what extent will they help meet veterans' long-term care needs in those areas?

Answer:

State (locality)	Project
MD (Charlotte Hall)	Construct 126 Bed Dom/NH (4th Phase)
AR (Little Rock)	Convert 70 Dom Beds to Nursing Home
FL (Lake City)	Construct 150 Bed Dom
MO (St. James)	Replace NH Unit (+ 50 beds)

Florida is a new State in the State Veterans Home Program. Maryland is a recent addition and this is another phase to its first State home. Arkansas is converting 70 of its 150 domiciliary beds to nursing home beds to accommodate nursing home patients. Missouri is expanding its State nursing home care program to assist more veterans. These projects will supplement the VA and community in meeting the long term needs of veterans in these States.

Question b. What is the remaining backlog of approved, unfunded projects? Are any of these projects in areas of greater need than the 16 projects to be funded in fiscal year 1987?

Answer: At the end of FY 1985, there were 72 eligible preapplications and applications on hand for $175,130,000 in grant requests. More than half of the number of grant requests, totalling $64,451,000, will be funded with the remaining FY 1985, FY 1986, and requested FY 1987 appropriations. Of the 34 remaining unfunded grant requests ($110,679,000), 13 requests ($78,194,000; 70.6 percent) are for bed producing projects. In general, VA approves projects in the order in which the completed pre-application was received; at this time, the VA has not established criteria to determine the relative need of grant requests either in regard to the priority amongst bed-producing projects; or between bed-producing, life safety, handicap accessibility, patient environment improvement, or other renovation/remodeling projects.

Question: 16. In 1983 GAO evaluated how VA ensures that its health research findings are used, to the extent feasible, in providing health care to veterans. (Letter to the Chief Medical Director, GAO/HRD-84-18, October 24, 1983). GAO stated that while VA research findings are widely disseminated, it is done without (1) differentiating between findings that are ready for clinical application and those that are not or (2) ensuring that clinicians in a position to use the findings receive them. VA subsequently agreed to establish a process for (1) reviewing and evaluating research findings to identify those having potential for immediate application in the VA health care system; (2) targeting dissemination of this information to the appropriate VA clinicians; (3) following up to obtain feedback from clinicians on the use or non-use of research findings, along with the effects of use or the reason for non-use; (4) using the feedback, where appropriate, to encourage wider use or to plan additional research.

Question: a. Has VA established a process which addresses these issues?

Answer: Pursuant to the subject report, DM&S established a task force that met in November 1983, and June, October and December 1984, to discuss how each Research and Development Service could improve the transfer of research findings into practice, within existing resources. Each R&D Service has addressed these concerns in its processes; each uses a slightly different approach as discussed in the answer to part b. of this question.

Question: b. If so, what specific research results have been targeted to the appropriate clinicians?

Answer: The HSR&D Service has distributed one Bulletin targeted to Chiefs of Staff and Associate Chiefs of Staff for Ambulatory Care, entitled "Chest Pain

Diagnosis." Additional Bulletins are scheduled for publication every six weeks. The next three scheduled address: Foley Catheter Care Regimens; Influenza Vaccination; and Algorithms for Nurse Practioners. For Medical Research Service, the publication of research findings in professional journals remains the primary dissemination mechanism by which clinically relevant research findings are communicated to clinicians. At the request of the GAO the VA has established a process by which clinically useful research findings are brought to the attention of the Directors of clinical services in Clinical Affairs. Medical Research Service has identified 28 clinician scientists in different research specialities and throughout the VA who annually summarize clinically relevant research contributions of VA scientists. These summaries are made available to the senior staff of Clinical Affairs in VACO for dissemination to staff clinicians in the field. In fact, important clinical research advances are very rapidly disseminated by the professional and lay press immediately after the original research report is published.

A Clinical Supplement to the Journal of Rehabilitation Research and Development is issued in special topical areas of rehabilitation. The first Clinical Supplement which was published in FY 1986 addressed the topic of physical fitness and recreational aids for the disabled. Plans for future issues include comprehensive coverage of such topical areas as wheelchairs, upper extremity prostheses, external power systems for upper extremity prostheses, management of the insensate foot, aids for the hearing impaired, aids for the visually impaired, AND clinical gait analysis.

State of the art conferences are routinely conducted by the Rehab R&D Service in its priority areas of prosthetics/amputations/orthotics, spinal cord injury, and sensory aids. Participants in these meetings include disabled veterans, related interest groups, government and private officials, professionals, consumers, researchers and health care deliverers. These extensive discussions have produced recommendations for research in the priority areas.

Question: c. If not, why hasn't this process been established and how does VA ensure that its research results are used appropriately?

Answer: Not applicable.

Question 17: On page 6-14 of the budget document, "Medical Programs Fiscal Year 1987 Volume II", it states:

> The creation of new medical knowledge in support of the health care mission is a significant goal of research on war-related afflictions and prevalent diseases among veterans.

Please provide by category (i.e., investigator-initiated, cooperative studies, etc.) the number, subject, and cost of the research on war-related afflictions.

Answer:

Category	FY 1987 Number	Cost
Agent Orange Office		
Agent Orange	9	$1,090,000
Epidemiology Study	1	3,701,000
Investigator-initiated		
Spinal Cord Injury	15	1,458,000
Head Injury	1	198,000
POW	1	256,000
Career Development		
PTSD	1	75,000
Cooperative Studies		
Agent Orange	1	350,000
High Priority		
PTSD	3	128,526
Spinal Cord Injury	7	473,133
Agent Orange	7	353,887

Question 18: On page 6-11 of the budget document, "Medical Programs Fiscal Year 1987 Volume II", it states that 24 cooperative studies are in progress, 11 are in the planning phase, and 6 are in the final phase of analysis. Please provide a breakdown by number, subject and cost of each investigator-initiated, career development, high priority research, and agent orange study. Which, if any, of the agent orange studies is expected to be completed during fiscal year 1987?

Answer: The attached table provides the requested breakdown identifying the funding by major subject area and is based upon FY 1985 information, the latest year for which data are available. It is not possible to identify future funding by project. However, the ratios have stayed the same over a number of years and it can be anticipated that the statistical relationship will not change significantly.

All VA conducted agent orange studies resulting from a special solicitation in 1982 will be completed in FY 1987. Additional agent orange studies will be investigator-initiated programs.

PROGRAM AREA	1987 ($ 000)	PROGRAMS
* AGING	3797	53
* ALCOHOLISM	5672	79
AUDIOLOGY & SPEECH PATHOLOGY	1162	16
BASIC SCIENCES	15034	208
* BEHAVIORAL SCIENCES	5870	81
* CARDIOVASCULAR DISORDERS	11709	162
CLINICAL PHARMACOLOGY	1796	25
DRUG DEPENDENCE	892	12
ENDOCRINOLOGY & METABOLISM	16037	222
GASTROENTEROLOGY	10637	147
HEMATOLOGY & SICKLE CELL	6842	95
IMMUNOLOGY	8373	116
INFECTIOUS DISEASES	8831	122
* MENTAL HEALTH	4900	68
NEPHROLOGY	6780	94
* NEUROLOGY & NEUROBIOLOGY	12748	176
NUCLEAR MEDICINE & RADIATION	1778	25
NURSING	1858	26
ORAL BIOLOGY	1849	26
* ONCOLOGY	6180	86
PATHOLOGY	1718	24
RADIOLOGY	644	9
REHABILITATIVE MEDICINE DISEASE	313	4
RESPIRATION & PULMONARY DISEASE	6189	86
SOCIAL WORK DISORDERS	7	1
* SPINAL CORD DISORDERS	1558	22
SURGERY	5378	74
VISION	843	12
DERMATOLOGY	834	12
ORTHOPEDIC SURGERY	$528	7
* OTHER	13512	188

* THESE PROGRAMS CONTAIN THE HIGH PRIORITY RESEARCH AREAS. "OTHER" INCLUDES PRISONER OF WAR STUDIES, AGENT ORAGNGE SOLICITATION AND STUDIES RELATED TO PROBLEMS OF FEMALE VETERANS.

Question 19: Please provide an analysis of methods used, if any, to determine the relative importance of investigator-initiated studies as compared to high priority research, including an explanation of the reason for a $4.1 million reduction in veteran-specific high priority research.

Answer: Investigator-initiated research studies provide the infrastructure of the VA's research effort. The great majority of these studies are developed by VA clinicians who derive their research questions from the medical problems they encounter in caring for veteran patients. Occasionally, an area is designated High Priority because a unique opportunity exists to study a medical condition prevalent among veterans. The VA recruits established investigators to undertake new studies in areas such as the basic biological processes underlying schizophrinia, alcoholism and aging. Once these investigators initiate these special studies, their continuation falls into the investigator-initiated category. Thus, the $4.1 million reduction in high priority areas signifies the maturation of high priority research studies into the investigator-initiated category.

Question: 20.

What percentage of the $16.5 million rehabilitation research budget will be devoted to research activities (as compared to personal services, travel and transportation, etc)?

(a) Please provide a breakdown by number, subject, and cost within each category (i.e., prosthetic/amputation/orthotics, spinal cord injury, and sensory aids) of rehabilitation research projects.

Answer: The attached listing provides a breakdown of the number, costs and subject areas of the Rehab R&D projects in FY 1986. The additional funding projected for FY 1987 will provide augmented support for projects in the area of computer aided design/computer aided manufacture (CAD/CAM) of prostheses, for robotics, and for sensory aids. New studies in the various priority areas identified for Rehab R&D will begin as older studies are completed or terminated.

Rehabilitation Research and Development Projects FY 1986

137 Projects

Prosthetics/Amputation/Orthotics
(40 percent of total projects)

Internal Joints & Prosthesis	15	
Diagnostic Procedures	14	
Prosthetics/Orthotics	9	
Surgical Procedures	6	
Mobility	3	
Manipulative Devices	2	
Therapeutics	2	
Gait Analysis	1	
Maxillofacial Prosthesis	1	
Total	53	projects

Spinal Cord Injury
(30 percent of total projects)

Diagnostic Procedures	13	
Neuromuscular Controls	6	
Internal Joint/Prosthesis	5	
Surgical Procedures	4	
Manipulative Devices	3	
Mobility	3	
Prosthetics/Orthotics	2	
Other	2	
Total	38	projects

Aging and other
18 projects
(10 percent of total projects)

Sensory Aids
(20 percent of total projects)

Deafness and Hearing Impaired	7	
Diagnostic Procedures	6	
Speech Impairment	6	
Blindness and Visual Impairment	5	
Internal Joint/Prosthesis	1	
Manipulative Devices	1	
Therapeutic	2	
Total	28	projects

Rehabilitation Research and Development Funding FY 1985

Prosthetics/Amputation/Orthotics	$ 4.7 million
Spinal Cord Injury	$ 4.7 "
Sensory Aids	$ 2.2 "
Centers and Units	$ 3.4 "
Other Initiatives	$ 0.4 "
Total	$15.4

Question: 20(b). How many investigator-initiated rehabilitation research projects will be funded, what is the subject and cost of each project?

Answer: We project that 148 projects will be funded in FY 1987; 141 of these will be investigator-initiated.

Question: 21. What specific plans do you have to implement any of the Decision Support Technology discussed during the 1985 conference? (page 6-19).

Answer: The conference recommendations are being considered. Plans to address them will be considered in future budgetary deliberations. The proposed budget does not contain these resources.

Question: 22. Please provide a copy and analysis of the proposed agenda to help the VA address the growing challenge of health and social service needs of aging veterans. (page 6-19).

Answer: The HSR&D Service has developed a conceptual framework for addressing health services research issues related to aging. The approach continues to guide health services research planning, encompassing such areas as: encouraging health services research related to aging; and developing information syntheses on pertinent topics.

Department of Medicine and Surgery Washington D.C. 20420

Veterans Administration

IL 15-84-12

November 2, 1984

In Reply Refer To: 152

RESEARCH AND DEVELOPMENT LETTER

TO : Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics (151/152)

SUBJ: A White Paper Prepared by HSR&D Investigators Austin, Durham, Hedrick, Pearlman, and White: "Meeting the Needs of the Aging Veterans: A Health Services Research Agenda" (HFP 40-61-180)

1. Please bring this letter — and the existence of the subject HSR&D Service product — to the attention of HSR&D investigators and of VA staff responsible for the care of the aging veteran. The paper was prepared by Carol Austin, Ph.D., Mary Durham, Ph.D., Susan Hedrick, Ph.D., Robert Pearlman, M.D., and Diana White, M.S. of the Northwest HSR&D Field Program, with the support of the HSR&D Service.

2. An executive summary of the document is included as an attachment to this letter. Copies of the complete report may be obtained from the HSR&D Service (152), VA Central Office.

3. Questions regarding this letter should be directed to Dr. Peter Goldschmidt at FTS 389-2666 or to Mrs. Carolyn Smith (HSR&D Service), at FTS 389-2573.

HOLLIS G. BOREN, M.D.
Assistant Chief Medical Director
for Research and Development

Attachment

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ATTACHMENT A

IL 15-84-12
November 2, 1984

EXECUTIVE SUMMARY

"Meeting the Needs of the Aging Veteran: A Health Services Research Agenda"

Resource on Aging/VA Northwest Regional HSR&D Field Program
Carol Austin, Mary Durham, Susan Hedrick, Robert Pearlman and Diana White

This report proposes a health services research agenda in geriatrics/gerontology for the Veterans Administration and offers recommendations for its implementation.

The agenda is based on findings from a modified Delphi study involving two expert panels. The first Panel (Panel A) included a multidisciplinary group of VA and non-VA providers and administrators responsible for providing care to the elderly (N=128). These respondents identified problems related to care of the elderly and then ranked and rated the importance of each. Project investigators classified this comprehensive range of problems into a typology which included 19 subcategories organized into the following six major categories:

- Clinical
- Patient and Family
- Provider
- Organizational and System
- National and VA System Policy
- Ethical Issues

Analysis of Panel A responses indicates that perceptions of problem priorities were consistent across three broad groups of Panel A respondents (physicians/non-physicians, administrators/non-administrators, VA/non-VA providers).

The second Panel (Panel B) was composed of researchers with expertise in geriatrics/gerontology and/or health services research (N=38). Panel B respondents formulated research questions based on specific problems presented in the typology for which they had expertise. Panel N respondents were then asked to assign priorities to all questions within a major typology category.

The research agenda was constructed by identifying the overlap between problem areas rated as most important by Panel A and research questions assigned highest priority by Panel B. The agenda includes research questions on the following topics:

Service Utilization

- veterans utilization of health care programs
- the effect of socioeconomic status on acute and long term care utilization

Providers

- physician education in geriatrics/gerontology
- effects of alternative training programs on provider attitudes toward the elderly
- provider/patient communication affecting iatrogenic complications from medications

Components of Comprehensive Services for Elders

- comprehensive assessment
- informal support systems
- case management
- alternative living situations

- respite care
- alternative approaches to pooling long term funding
- community based long term care (home care/day care)
- prevention and health maintenance programs

Recommendations

Implementation of the research agenda is addressed in three sets of recommendations.

Research Strategies and Designs

Since many of the research questions have had limited empirical investigation, research strategies should be developmental, appropriately reflecting the state of the art in the individual topic areas. The following generic sequence of research designs and methodologies is recommended:

1. descriptive surveys and epidemiological investigations
2. information syntheses
3. pilot projects and evaluations
4. multi-site demonstration projects and evaluations
5. program implementation and monitoring

Supportive research activities designed to enhance measurement capability and to develop information systems will be necessary throughout the recommended sequence.

Administrative Support

Several kinds of administrative supports will be necessary in order to implement the research agenda. These include:

- improved capacity in information and cost measurement systems
- requirements for program impact evaluations
- procedures for multi-site collaborative HSR&D studies
- incentives for Medical Center administrators to participate in research
- sanction from VACO for studies focused on system change
- enhancement of program flexibility to facilitate research

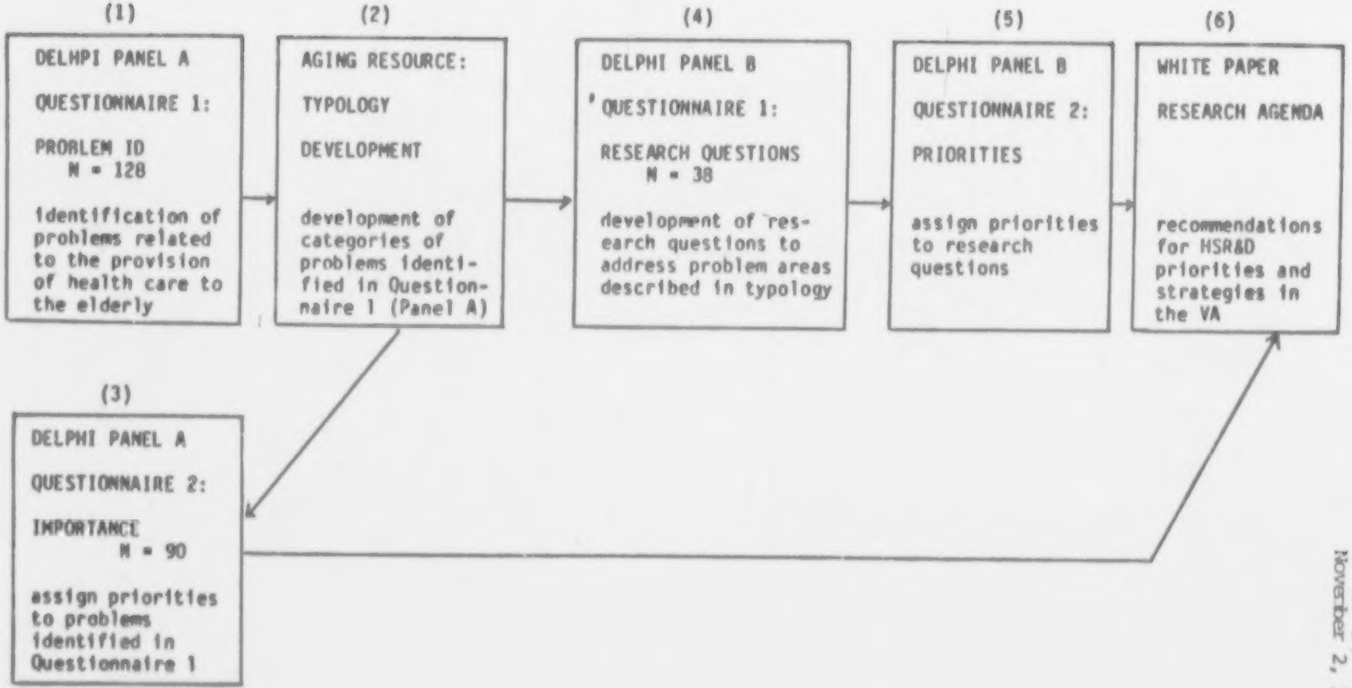
Action Recommendations

In the short term several recommendations for action can facilitate the implementation of the research agenda.

- broad dissemination of this report to educate and stimulate research in geriatrics/gerontology
- feasibility assessment of pursuing highly rated research areas by HSR&D in VACO
- development of special announcements and requests for proposals based on the research agenda
- fostering of collaboration within and outside the VA in the design and implementation of research
- coordination with other federal agencies so that VA research activities complement and do not duplicate previous and current studies
- development of information syntheses on topics described in this report

Figure 1

Design Overview


(1)
DELHPI PANEL A
QUESTIONNAIRE 1:
PROBLEM ID
N = 128
identification of problems related to the provision of health care to the elderly
(2)
AGING RESOURCE:
TYPOLOGY
DEVELOPMENT
development of categories of problems identified in Questionnaire 1 (Panel A)
(4)
DELPHI PANEL B
QUESTIONNAIRE 1:
RESEARCH QUESTIONS
N = 38
development of research questions to address problem areas described in typology
(5)
DELPHI PANEL B
QUESTIONNAIRE 2:
PRIORITIES
assign priorities to research questions
(6)
WHITE PAPER
RESEARCH AGENDA
recommendations for HSR&D priorities and strategies in the VA
(3)
DELPHI PANEL A
QUESTIONNAIRE 2:
IMPORTANCE
N = 90
assign priorities to problems identified in Questionnaire 1

MEETING THE NEEDS OF THE AGING VETERAN: A HEALTH SERVICES RESEARCH AGENDA

HSR&D Document # HFP 49-61-180

Abstract

Meeting the health and social service needs of aging veterans is a major challenge facing the Veterans Administration. To help the VA address these needs, this report provides an empirically-derived list of principal problems related to the care of the aging veteran and suggests an health services research agenda for the VA. The agenda is based on the findings of a modified Delphi study using two panels of experts. One (Panel A) was composed of VA and non-VA providers and administrators (N=128) who identified and prioritized problems relating to the care of the elderly; another (Panel B) was composed of health service researchers (N=38), including those with special expertise in geriatrics and gerontology, who formulated and prioritized a comparable set of research questions, based on the typology of problems generated by Panel A. The final research agenda consists of the most important research questions (identified by Panel B) falling within the most critical problem areas (identified by Panel A). These thirteen questions/topics are grouped into three major categories: service utilization, providers, and components of comprehensive services for elders. The report also provides recommendations relating to research strategy and designs, administrative support, and action steps to facilitate the implementation of the health services research agenda in the VA.

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The HSR&D Team

This report was developed by an HSR&D Service Team based at the Northwest HSR&D Field Program. It represents a required product of the system-wide resource on care of the aging veteran housed at that Program. The authors are: Carol Austin, Mary Durham, Susan Hedrick, Robert Pearlman, and Diana White. Thomas S. Inui, Sc.M., M.D. is Director of the Northwest HSR&D Field Program.

For More Information

Peter G. Goldschmidt, M.D.
Director, HSR&D Service (152)
Veterans Administration
Washington, DC 20420
(202) 389-2666

HFP 40-61-18

FINAL DRAFT

WHITE PAPER

MEETING THE NEEDS OF THE AGING VETERAN:
A HEALTH SERVICES RESEARCH AGENDA

Resource on Aging

Veterans Administration

Northwest Regional Health
Services Research and
Development Field Program

Carol Austin, Mary Durham, Susan Hedrick, Robert Pearlman and Diana White

April 2, 1984

The authors assume equal responsibility for this document and are listed alphabetically.

The authors wish to acknowledge the participation of Michael McCally in the development of this project.

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I. INTRODUCTION

Planning for Older Veterans

Meeting the health and social service needs of aging veterans is a major challenge facing the Veterans Administration (VA). Providers and planners involved in health care services have been particularly concerned as growing numbers of elderly veterans with multiple, chronic medical problems place increasing demands on the health care system. The number of veterans 65 years and older will triple between 1981 and 2000. By the year 2005 the number of veterans over 75 years of age, a group with greater health care problems, is expected to be six times greater than it was in 1981. While not all eligible older veterans will choose to use its services (1), the VA anticipates increased demand for care from this age group (2). VA clinicians and administrators must respond to the current needs of the aging veteran population and plan for the future. This paper reports on an effort by the Veterans Administration Health Services Research and Development Service to identify current problems encountered in providing health care to elderly veterans and to develop a research agenda to address these problems.

In this context, the existing configuration of VA services may be unable to meet the needs of the elderly veteran population. Currently, the VA is engaged in a planning process to develop a VA Plan for Older Veterans which will set forth directions the VA intends to follow to meet the needs of older veterans. In a related effort, in 1983 Durham described a model health services system which would provide comprehensive care and a full range of coordinated, community linked services focused around the VA medical center as a central entry point (3). A VA Special Medical Advisory Group (SMAG) Task Force on the VA Geriatric Plan (2) recommended an expanded role for VA

Medical Centers in the provision of chronic care services and closer collaboration with community agencies. The SMAG report also "strongly recommended the use of research and demonstration projects to evaluate the cost, effectiveness, manpower needs and appropriate organizational and manpower configurations of innovative delivery models" (p. iv).

While the general targets for policy change and planning for care of older veterans have begun to be identified, a comprehensive set of research questions has not been developed. The project reported in this paper focused on the systematic identification of problems and needs regarding care of the aging veteran in order to specify health services research priorities for the VA. The major problems reported here represent those encountered by a wide array of individuals who are actively involved in the care of older people. The primary goal of the project was to provide the VA with an empirically derived list of principal problems related to the care of the aging veteran which might serve as a focal point for health services research in the VA. The first set of tasks were to identify and assign priorities to significant problems in the provision of health and social services to aging veterans. Next, the problems were transformed, where possible, into health services research questions and placed in order of priority. Third, a research agenda for the VA was developed to facilitate improvements in the quality and management of health care services to older veterans.

Geriatric Health Services Research

Several investigators have identified a multitude of problems associated with the provision of health care to the elderly. Eisdorfer has mentioned acute disease oriented attitudes of providers as a principal problem and other issues such as the hospital as a site for care, inadequate support for informal caregivers, inadequate financial reimbursement for social and adaptive interventions and the depreciation of the social approach to health care in medical education (4). Kane and Kane have discussed problems associated with the costs of care and problems in the communication and balance between health and social services. They identify fragmented delivery systems, lack of incentives for alternative care programs and information gaps regarding the effectiveness of various institutional and community programs as issues requiring attention (5,6). A frequently mentioned problem is the area of information dissemination and the gap between research findings and their application in the delivery of care (6,7,8). Several recent VA reports call for the development of a coordinated, comprehensive, community linked approach to meeting the chronic care needs of vulnerable elderly veterans (2,3). This partial listing of problems which interfere with the delivery of high quality health care to the elderly reflects the perceptions of academic investigators and the collective recommendations of designated VA committees. The issues are wide ranging, and lack an empirically based conceptual framework and a mechanism to establish priorities among the numerous problems.

Topics for research in geriatric care have also received considerable attention from several analysts. Kane and Kane have suggested the importance of research to address substitutions for nursing home care, strategies for care within alternative programs (e.g., home care, day care, sheltered housing), strategies for targeting services, measurement techniques to assess effectiveness and costs, the role of the informal caregiver and approaches to changing current financing/reimbursement policies (5,6). The National Institute on Aging recommends studies to investigate risk factors, barriers to the receipt of health care, provider behavior and attitudes that affect patient care and the effects of polypharmacy among other issues (9).

In a recent study, Moran and Soumerai sought to develop a health services research agenda for the Veterans Administration that focused on the needs of the aging veteran population (10). This effort started with an informal survey of knowledgeable geriatricians and others familiar with VA care for the elderly. The questionnaire was administered to 26 Geriatric Research Education and Clinical Center (GRECC) directors and geriatricians, a group composed almost exclusively of clinicians and biomedical investigators. Seventeen of the 26 respondents completed the questionnaires. These individuals were asked to define a range of problem areas for inquiry which were used by the investigators to develop a priority setting questionnaire. Moran and Soumerai identified six priority areas for future research:

1. Effects of audits, interventions and structural characteristics on optimal drug utilization;
2. Cost effectiveness of the identification of cognitive and emotional disorders;
3. Effectiveness of nutritional risk screening and education programs to improve dietary patterns;
4. Utility of existing functional assessment tools for improving clinical and case management decision making;
5. Effectiveness of programs to coordinate care for frail elderly both within the VA and between the VA and community services organizations;

6. Cost effectiveness of alternative combinations of services and personnel.

The project described in this report complements previous research agenda setting efforts by starting with problems identified by clinicians and administrators engaged in the delivery of care to older people (N=128). These problems formed the foundation of a typology, a classification system, from which health services researchers (N=38) developed research questions which VA investigators may pursue.

II. STUDY DESIGN

Overview

The development of a VA agenda for geriatric health services research required the assistance of VA and non-VA managers, clinicians and researchers nationwide. A modified Delphi technique was used to systematically elicit expert opinion from a geographically dispersed group of respondents. The Delphi technique is used to pool judgment and reach consensus about a particular problem or topic through an iterative group process. Multiple questionnaires used in the standard Delphi technique are employed to achieve a strong consensus on the topic of interest. The investigators decided that sufficient information to develop a useful research agenda could be gathered with two questionnaires, thereby keeping respondent burden to a minimum and enhancing response rates.

Two separate panels of experts were developed for this project. The first, Panel A, represented VA and non-VA managers and clinicians who are familiar with major problems facing older persons. The second panel, Panel B, was composed of professionals who have expertise in gerontology and/or health services research.

This approach was taken in order to ground the research agenda in an empirically derived set of problems identified by individuals directly involved in the provision of care to elders. Project investigators developed a typology of these problems. Expert health service researchers were then asked to write research questions in a specific category of the typology. With this approach, project investigators sought to bring together the expertise and experience of two important groups, practitioners and researchers, and to strengthen the foundation upon which the research agenda would be built.

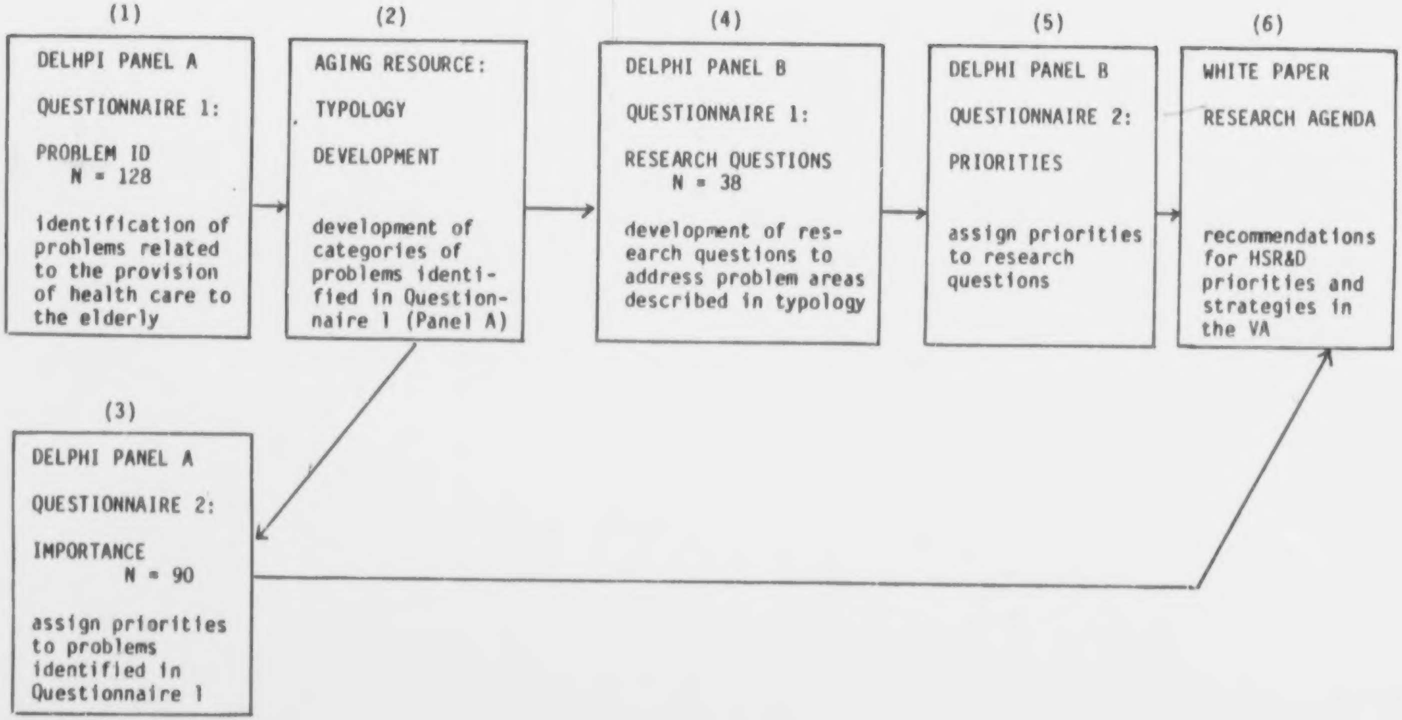
The sequence of project activities is presented in Figure 1 (p. 10). In Step (1), a questionnaire was sent to members of Panel A, a multidisciplinary group representing 16 disciplines (N=128). They were asked to identify problems regarding the delivery of health care to the aged. They responded with over 387 problem statements. In Step (2), we constructed a typology of problems from the 387 problem statements generated by Panel A members. A second questionnaire was developed from the typology and returned (Step 3) to Panel A repondents. They were asked to rate and rank items in terms of their importance to health care provision for aged veterans.

At this point, the second panel, Panel B, was formed. This group was composed of gerontological/geriatric and health services researchers. In Step (4), they were asked to generate research questions for specific typology subcategories for which they had expertise. In a questionnaire that followed (Step 5), Panel B respondents were asked to assign priorities to research questions in the broader typology area to which they contributed questions and to identify the top three questions which they believed merited research funding.

This report presents the analysis of both panels' data and a synthesis of these data which provide the empirical base for a systematically derived research agenda. In the discussion that follows, project methods and findings are described in greater detail.

Figure 1

Design Overview


(1)
DELHPI PANEL A
QUESTIONNAIRE 1:
PROBLEM ID
N = 128
identification of problems related to the provision of health care to the elderly
(2)
AGING RESOURCE:
TYPOLOGY
DEVELOPMENT
development of categories of problems identified in Questionnaire 1 (Panel A)
(4)
DELPHI PANEL B
QUESTIONNAIRE 1:
RESEARCH QUESTIONS
N = 38
development of research questions to address problem areas described in typology
(5)
DELPHI PANEL B
QUESTIONNAIRE 2:
PRIORITIES
assign priorities to research questions
(6)
WHITE PAPER
RESEARCH AGENDA
recommendations for HSR&D priorities and strategies in the VA
(3)
DELPHI PANEL A
QUESTIONNAIRE 2:
IMPORTANCE
N = 90
assign priorities to problems identified in Questionnaire 1

PANEL A DELPHI

Identification of Geriatrics Care Problems

Panel A: Problem Identification and Priority Setting

Panel Composition

The task of problem identification for geriatric health services research required the expertise of a panel of VA and non-VA clinicians, managers and researchers familiar with major problems older individuals encounter in their efforts to obtain health and social services. Panel members were identified by project investigators. The panel was composed of eight persons in each of 15 different disciplines involved in geriatric care (N=120): administration, dentistry, dietetics, health services research, geriatric medicine, nursing, optometry, pharmacy, podiatry, psychiatry, psychology, rehabilitation medicine, speech pathology/audiology, social work and team training/education. In addition, representatives of advocacy groups (both aging and veterans' organizations) were included in the sample (N=8). Within each of the 15 disciplines, four categories of experts were selected for participation:

1. VA Central Office (VACO) Officials. One respondent from each discipline listed above was selected for his or her knowledge of system-wide geriatric care problems and needs (N=15);
2. VA Service Chiefs. Two VAMC Service Chiefs in each discipline were included in order to identify service level problems (N=30);
3. VA Practitioners. Three VAMC practitioners from each discipline within three VA facilities (Seattle, American Lake, Portland) were chosen for their knowledge and involvement with health care of aging veterans. This group of respondents was represented by three rather than two respondents in each discipline, in order to give additional weight to the clinical practitioners' experience (N=45);

4. Non-VA Experts. Two non-VA individuals in each discipline were included for their knowledge of gerontological health care delivery (N=30).

Respondents at both the Service Chief and practitioner levels were selected largely from three VA Medical Centers: American Lake (a hospital with an emphasis on neuropsychiatry and chronic care), Portland, and Seattle (two large, tertiary care, affiliated institutions). At American Lake a total of 13 respondents participated (five service chiefs and eight practitioners). Twenty-eight respondents were involved at Portland (13 service chiefs and 15 practitioners). Twenty-six respondents participated from Seattle (9 service chiefs and 17 practitioners). These three medical centers were chosen because the investigators were located at these facilities and had ready access to the staff. Further, the investigators believed that responses provided by these individuals would be representative of responses from others at VA facilities across the nation. Respondents from other VA medical centers (N=8) were included when the investigators judged that they were more knowledgeable of geriatric/gerontological issues than local professionals.

The sample of advocates was drawn from both veterans organizations and organizations representing the broader elderly population. These individuals were chosen to represent the aged and the aged veterans' point of view. Respondents were associated with the Department of Veterans' Affairs, Veterans of Foreign Wars, Veterans' Benefits Counseling, the National Council on Aging, the Gray Panthers, an Area Agency on Aging, and a long term care ombudsman program.

Data Collection: Questionnaire 1

In order to identify the major problems that Panel members associated with care of the elderly, each of the 128 respondents were sent a questionnaire which asked them to "name and briefly describe three to five problems related to the provision of geriatric health services". Panel members were asked to draw upon their own experience as a clinician, manager or researcher. They were not asked to limit their comments to their own disciplinary focus.

Seventy percent of the sample responded (N=90), with all disciplines and categories of panel members (e.g., VACO, VA and Non-VA, etc.) well represented in the response pool.

Data Analysis: Typology Construction

Three hundred and eighty-seven (387) problem statements were generated from the first questionnaire. The problem statements were evaluated independently by the investigators, each of whom prepared a preliminary typology which grouped like responses together into a number of major categories. The group of investigators then met and, through discussion and consensus, constructed a final typology consisting of six categories and 19 sub-categories. The categories and associated sub-categories are summarized in Table 1 (p. 15). Brief descriptions of each sub-category are provided in Appendix A.

Data Collection: Questionnaire 2

The purpose of the second questionnaire was to obtain opinions from Panel A regarding the relative importance of each of the problems identified in the first questionnaire. Respondents were asked to "rate each problem in terms of its seriousness as a barrier to the provision of health care to elderly

TABLE 1

TYPOLOGY OF PROBLEMS RELATED TO CARE OF THE ELDERLY

(Number of Panel A Respondents = 90)

I. Clinical Problems (N=105 problem statements)

   A. Lack of Preventive Care (N=7)
   B. Difficulties Identifying Patient Needs (N=26)
   C. Lack of Effective Therapeutic Intervention Programs (N=59)
   D. Iatrogenesis (N=13)

II. Patient/Family Barriers (N=48 problem statements)

   A. Lack of Patient/Family Knowledge (N=19)
   B. Lack of Motivation (N=13)
   C. Socio-economic Problems of Older People (N=16)

III. Provider Barriers to the Provision of Health Care (N=92 problem statements)

   A. Lack of Knowledge (N=39)
   B. Negative Attitudes (N=25)
   C. Interprofessional Relationship Difficulties (N=6)
   D. Management and Staffing Problems (N=22)

IV. Organizational and System Problems (N=90 problem statements)

   A. Lack of Continuity and Coordination in Patient Care (N=29)
   B. Lack of Adequate Information Systems (N=4)
   C. Lack of Comprehensive Continuum of Care (N=57)

V. National and VA System Policy Barriers (N=45 problem statements)

   A. Lack of Support for Preventive Health Care, Health Maintenance and Chronic Care Programs (N=21)
   B. Reimbursement, Reallocation Barriers (N=15)
   C. Restrictive Eligibility Requirements (N=9)

VI. Ethical Issues (N=7 problem statements)

   A. Personal Values of Providers (N=3)
   B. Justice and Equity in Health Care (N=4)

patients". The second questionnaire contained 92 separate problem statements which were developed from the typology based on responses from the first questionnaire. Problem statements were grouped under the appropriate typology sub-heading. The number of items for each typology subcategory ranged from one to 16. Respondents were asked to rate each problem statement on a seven point Likert scale where (1) represented "minimal importance" and (7) indicated "extreme importance". Only the end points of the scale were labeled. Respondents were instructed that the extreme end of scale ("extreme importance") should be used only for those problems which were viewed as being most serious as a barrier in the provision of health care to elderly patients.

Questionnaires were mailed to the 90 individuals who completed the first questionnaire. Seventy-seven were returned, an 86% response rate for the second Delphi round. Sixty percent of the original panel of 128 completed both questionnaires, a respectable response rate for Delphi studies.

Findings

Analysis of responses from the second questionnaire identified the patient care problems that were perceived by our panel members as the most significant barriers to the provision of high quality care. Table 2 (p. 17) lists the 15 problems which were most highly rated and ranked by our respondents.

Mean ratings, obtained through calculations of the Likert score, had an observed range of 3.56 (SD = 1.58) to 5.88 (SD = 1.32), scores falling in the middle of the 7 point scale. The 15 highest-rated problems had mean rating scores from 5.24 (SD = 1.20) to 5.88 (SD = 1.32). Table 2 (p. 17) also lists the rankings for the 14 most highly ranked problems. Scores for the rankings were obtained from responses to our request to identify, in order, the five most serious problems listed on questionnaire 2. This method for determining

TABLE 2

PROBLEMS WITH HIGHEST IMPORTANCE RATINGS AND RANKINGS

(Number of Panel A Respondents = 77)

Mean** Rating	(Mean** Ranking)	Questionnaire Item	Typology Category
5.88	(2)	Emphasis by the medical care system on acute care at the expense of preventive care, rehabilitation services, and health maintenance services.	Policy: lack of support for preventive care, health maintenance, and chronic care programs (VA)
5.78	(1)	Lack of financial resources needed by older people to purchase health care, social support services, and therapeutic aids.	Patient/Family Barriers: Socioeconomic Problems of older people (IIC)
5.77	(3)	Lack of consideration of the impact of multiple physical, social, and psychological problems on the lives of older people and their day-to-day functioning.	Provider Barriers: Negative attitudes toward care of the elderly (IIIB)
5.59	(11)	Lack of support (respite services, counseling, training, information) for family members caring for elderly patients (e.g., patients with dementia, patients recently discharged from hospitals, heavy-care patients for extended periods of time).	Organizational and Systems Problems: Lack of Alternative Models of Care (IVC)

* (-) indicates that the item did not occur in the top 14 ranking

** Mean rating scores were computed from responses on a 7 point Likert scale.
Mean ranking scores were computed from respondents' identification of 5 most important problems. Most important problems received 5 points, unranked problems received 0 points.

Table 2 (continued)

5.58	(4)	Lack of training in geriatrics and gerontology for physicians.	Provider Barriers: Lack of Knowledge (IIIA)
5.56	(-)*	Lack of alternatives of demonstrated effectiveness to nursing home and inpatient care, [specifically] respite care.	Organizational and Systems Problems: Lack of Alternative Models of Care (IVC)
5.50	(7)	Difficulties pertaining to the allocation of scarce resources for care of the aged.	Ethical Issues: Justice and Equity in Health Care (IVC)
5.49	(5)	Reliance on a medical model approach to patient care rather than on an approach that focuses on the total needs of the patient.	Policy: Lack of Support for Preventive Health Care, Health Maintenance, Chronic, Care Programs (VA)
5.41	(14)	Incompatible and/or inappropriate prescriptions of psychoactive drugs.	Clinical Problems: Iatrogenesis (ID)
5.40	(-)	Lack of alternatives of demonstrated effectiveness to nursing home and inpatient care [specifically] comprehensive home care services.	Policy: Lack of Support for Preventive Health Care, Health Maintenance, Chronic Care Programs (VA)
5.36	(-)	Negative attitudes of health providers toward caring for the elderly.	Provider Barriers: Negative Attitudes toward Care of the Elderly (IIIB)
5.35	(14)	Incompatible and/or inappropriate prescriptions of drugs [not specifically psychoactive drugs].	Clinical Problems: Iatrogenesis (ID)
5.27	(6)	Inadequate numbers of staff available for patient care.	Provider Barriers: Management and Staffing Problems (IIID)
5.26	(-)	Inappropriate use of therapies and/or treatment procedures leading	Clinical Problems: Iatrogenesis (ID)

Table 2 (continued)

		to medical problems (iatrogenesis).	
5.24	(-)	Failure of health care providers to learn about services given to older people by other health and social service professionals.	Provider Barriers: Interprofessional relationship difficulties (IIIC)

rankings is typically used in Delphi data analysis. Problems listed as most important received a score of five, the second most important a score of four, third most important a score of three, and so forth with unranked problems receiving a score of 0. The individual scores were summed.

The high priority problems identified through these ratings obtained from the Likert scores and from the rankings were compared. As shown in Table 2 (p. 17), rating and ranking responses were similar. Sixty-six percent of the highest rated problems were also identified among the highest ranked problems, indicating reasonable consensus between the two methods of assigning priorities. The three most important problems identified by each method were identical, though the order was reversed for the top two. The three most important problems were:

1. emphasis by the medical care system on acute care at the expense of preventive care, rehabilitation services and health maintenance;
2. lack of financial resources needed by older people to purchase health care, social support services and therapeutic aids;
3. lack of consideration of the impact of multiple physical, social and psychological problems on the lives of older people and their day-to-day functioning.

These and other problems were examined in terms of the typology distribution. As shown in Table 2 (p. 17), the group of top-rated and ranked items fell into all six main categories of the typology, indicating the range and complexity of problems which present major barriers to the care of the aged. In both the top-rated and ranked problems, approximately 30 percent of the problems fell into the category of provider barriers (Typology Category III) and about 20 percent of the problems reflected policy issues (Typology Category V).

The problem areas also were analyzed to ascertain whether respondent subgroups varied in their perceptions of problem priorities. Three groups were examined: physicians and non-physicians, administrators and non-administrators and VA and non-VA providers. Mean scores of the highest rated problems were compared for the three groups. T-tests indicated no significant differences among the groups. This suggested that problem priorities were consistent across these broad groups of respondents.

PANEL B DELPHI

Identification of Most Important Geriatrics Health Services Research Questions

Panel B: Research Question Identification and Priority Setting

Panel Composition

The first step in the Delphi process yielded a diverse set of problems which were encountered by health care providers. The problems expressed by our Panel A members were expressed as clinical or policy issues rather than as health services research questions. Further, some of the problems were not "researchable" given the state of the art, but were of interest to clinicians and relevant to the provision of high quality care to elders. Panel B was created to generate health services research questions from the problem statements and then to assign priorities to those questions.

Panel B was composed of 38 experts with considerable research experience in geriatric/gerontology and health services research. Two individuals were chosen by project investigators for each of the 19 subcategories in the typology. Expertise was recognized either by reputation, publications, or direct involvement in research on the subcategory topic.

Data Collection

In order to generate health services research questions for each area of the typology, the 38 Panel B experts were sent a description of the one typology subcategory for which they had been selected. The expert was asked to read the descriptive summary of the typology subcategory and "list three research questions you feel are most pertiment to the problem area....the three research questions you feel are most important and need to be studied as part of the effort to improve services to aging veterans".

Thirty-five respondents returned the first questionnaire for a 92 percent response rate. The three respondents who failed to return the first questionnaire were replaced on the panel.

The investigators reviewed and edited these questions to standardize the questions so that the Panel's next task, assigning priorities to each question, could be accomplished more efficiently. The meaning of each question was preserved to the greatest extent possible. Revisions were made to add clarity, reduce overlap, eliminate unnecessary background information and to put all statements into question form. Revisions were made in two steps. First each investigator independently reviewed and revised the questions according to the criteria described above. The questions were then examined by the entire group and consensus was reached regarding final wording and format.

The compiled research questions were returned to respondents for their assessment in a subsequent questionnaire. Each panel member was asked to review all questions in the category for which they had written research in the first questionnaire (including questions in the other subcategories). Six different questionnaires were prepared, one for each of the major typology categories. The number of questions reviewed by each respondent ranged from 9 to 20 depending upon the category (Typology Category I = 18 questions, II = 18 questions, III = 20 questions, IV = 13 questions, V = 14 questions and VI = 9 questions). A total of 82 questions were reviewed by Panel B members. Respondents were asked to indicate whether "you feel each research question should be given top, middle or low priority. In making these judgments, consider the impact of research findings on patient care". Panel members were also asked to select "the three research questions in your 'top priority' category you would most like to see funded". Funding was used as a proxy for highest priority and to force respondents to make choices among the research questions.

Data Analysis

The priorities assigned to the research questions by respondents were analyzed in two ways. First, mean rating scores were computed with a rating of high priority given three points; medium priority two points; and low priority one point.The second analysis used the respondents' ranking of the three questions they thought were the highest priority and should receive funding. A question ranked first priority received three points; second priority, two points; and third priority, one point. These scores were added and used to rank the questions.

Findings

Top Rated, High Priority Research Questions

A total of 82 research questions were assessed by Panel B respondents. The questions addressed a wide range of issues reflecting the comprehensive scope of the problems covered in the typology. In order to construct a research agenda, the investigators decided to focus on the top rated research questions. These represent the top third of the rated questions in each of the six typology major categories, a total of 27. An additional indication of their importance is indicated by ranks assigned to the questions by Panel B. All of these questions were ranked by at least one panelist as among the top three questions. These research questions are organized by typology category and presented in Tables 3 through 8 (pages 26 to 33).

Questions included in the Clinical Problems area encompass a wide range of issues. Respondents (N=7) indicated research was needed to address epidemiological questions to improve measurement, and to evaluate alternative approaches to patient education and the provision of care. More specifically, highly rated questions focused attention on prevention/health maintenance,

TABLE 3

Typology Category I: Clinical Problems

Top Rated (Seven Judges) High Priority Research Questions

Mean* Rating	(Mean** Ranking)	
2.57	(6)	What are appropriate prevention/health maintenance (i.e., screening and counseling) activities for elderly VA patients (65 years and older)? a. What health care problems (both physical and psychological) of the aging veteran can be ameliorated or prevented by early identification and treatment? b. What is the incidence/prevalence of these problems, particularly those regarding ambulatory diagnoses and "non-disease" oriented care? c. What is the impact of these problems on elderly VA patients (e.g., morbidity, functional status, quality of life)? d. What is the accuracy, availability, acceptability, efficacy and cost of screening/conseling activities? e. What tools should be developed for identifying individuals for whom preventive services should be made available?
2.57	(4)	What are the dimensions of functional, nutritional and mental status of the frail elderly and how can they best be measured in a way that assists the care planner in assessing patient need for home care.
2.42	(1)	What are the characteristics of a continuing care approach to discharge planning from acute care which a) would ensure the systematic identification of patients requiring continuing care and b) utilize procedures by which staff routinely re-contact and reassess the identified individuals.

*Mean rating scores were computed from respondents identification of high (3 points), medium (2 points) and low (1 point) priority.

**Mean ranking scores were computed from respondents identification of top three questions (first choice, 3 points; second choice, 2 points; third choice, 1 point). Scores were added to determine rank.

Table 3 (continued)

2.42	(4)	What is the relationship between clinical findings and physical dysfunction in the elderly? Which conditions have high risk and high prevalence? What interventions can be used to minimize dysfunction?
2.14	(4)	What is the therapeutic ratio (benefits to adverse effects) of specific interventions in the elderly? (In determining the therapeutic ratio, the duration of effects and multi-plicity of problems must also be considered).
2.0	(2)	To what degree do different methods of communication between providers and older patients reduce the incidence and/or severity of iatrogenic complications from medications?

TABLE 4

Typology Category II: Patient and Family Barriers

Top Rated (Six Judges) High Priority Research Questions

Mean* Rating	(Mean** Ranking)	
3.0	(4)	What models of respite care (e.g., organization of services, reimbursement policies) which do not disrupt family ties, are appropriate for families of older, confused, needy individuals?
2.66	(3)	What incentives would foster the creation of "surrogate" families for elderly individuals without families in order to provide support and assistance and to delay or preclude inappropriate institutional placement?
2.5	(5)	Under what circumstances (e.g., number of people in the household, level of disability, ownership/rental arrangement) is shared housing in combination with supportive homemaker or live-in help a feasible living arrangement which can address the income and long-term care problems of poor and disabled citizens?
2.33	(1)	What treatments or interventions that are typically used in acute and long-term health care settings for mentally impaired elderly can be effectively used by family caregivers? a. What are families' attitudes towards use of these treatments in a home setting? b. What are the specific factors in a home setting which either militate against their use or lend themselves to effective application? c. What strategies are effective in promoting their use by family members?
2.33	(5)	What is the effect of socioeconomic status on acute and long-term care utilization by aged individuals with comparable levels of health and functional impairments?

*Mean rating scores were computed from respondents identification of high (3 points), medium (2 points) and low (1 point) priority.

**Mean ranking scores were computed from respondents identification by top three questions (first choice, 3 points; second choice, 2 points; third choice, 1 point). Scores were added to determine rank.

TABLE 5

Typology Category III: Provider Barriers

Top Rated (Eight Judges) High Priority Research Questions

Mean* Rating	(Mean** Ranking)	
2.71	(5)	What is the most effective way to assist practicing physicans to acquire necessary gerontological/geriatric information (e.g., oral presentations at continuing education workshops, preparation of informational packets distributed to the physicians, convening special forums to discuss geriatric/gerontological issues)?
2.5	(1)	Is it more effective in terms of cost, patient acceptance, resource utilization, and patient outcomes (e.g., functional impairment, satisfying life situations) to use an interdisciplinary team approach with team decision making, or to use a non-physician case management system where someone planfully seeks multidisciplinary inputs for a particular patient?
2.28	(2)	How do alternative training programs affect the development of attitudes toward the elderly (e.g., do programs which rotate trainees through health care settings for diverse elderly - community clinic, private office, nursing home - result in more realistic attitudes about elderly than do programs which use only nursing homes as training sites)?
2.28	(2)	What is the optimal model for VA teaching nursing homes for training physicians (e.g., affiliation agreements, mix of professional/paraprofessional personnel, funding)?
2.28	(4)	How do the dynamics of the external and internal labor markets for personnel in the VA system affect career development among the health care disciplines most centrally involved in geriatric care?

*Mean rating scores were computed from respondents identification of high (3 points), medium (2 points) and low (1 point) priority.

**Mean ranking scores were computed from respondents identification of top three questions (first choice, 3 points; second choice, 2 points; third choice, 1 point). Scores were added to determine rank.

Table 5 (continued)

a. Do labor markets for health professionals efficiently move potential recruits to positions in Geriatric Services?

b. Does movement into a position in a Geriatric Service constitute an orderly stop in the professional career ladder of those involved? Is it viewed as a positive or negative move?

c. Are opportunities for professional advancement, promotion or movement into management a natural outgrowth for those occupying positions in Geriatric Services?

TABLE 6

Typology Category IV: Organizational and System Problems

Top Rated (Six Judges) High Priority Research Questions

Mean* Rating	(Mean** Ranking)	
2.5	(2)	How do the benefits and costs of case management (care coordination) vary with changes in three domains of case management: a. Case manager (care coordinator) training, skills, caseload, resources, experience and task definition? b. Case mix? c. Point of intervention in the patient's health care system experience of spell of illness?
2.5	(4)	What is the minimum data set for VA medical and health services that is required to provide coordinated and continuous care to the eligible population?
2.5	(1)	Is comprehensive assessment of elderly patients a cost effective method for delivering health care services (e.g., does it result in early detection or reduce service demands)?
2.5	(3)	What effects can be expected from community based non-institutional long-term care services provided by the VA and at what costs? a. What are the appropriate domains of expected outcomes and what are the best measures of these domains? b. How do the costs and effects differ among patient subgroups?

*Mean rating scores were computed from respondents identification of high (3 points), medium (2 points) and low (1 point) priority.

**Mean ranking scores were computed from respondents identification of top three questions (first choice, 3 points; second choice, 2 points; third choice, 1 point). Scores were added to determine rank.

TABLE 7

Typology Category V: National and VA System Policy Barriers

Top Rated (Six Judges) High Priority Research Questions

Mean* Rating	(Mean** Ranking)	
3.0	(2)	How do aging veterans utilize various health care programs (e.g., what portion of veterans' medical care is provided by the VA and by other providers; what providers for what services)?
3.0	(1)	What alternative approaches can be developed which pool various sources of funding for long-term care services (VA, Medicare, Medicaid) in order to: a. Complement of supplement what are now often duplicative programs? b. Assure an appropriate range of service availability to veterans in need of a full range of acute and LTC services? c. Reduce fragmentation in service delivery to veterans and their spouses?
3.0	(3)	How do varying reimbursement systems and rates affect the supply and demand of non-acute and preventive services?
2.6	(4)	What are the effects of increased out-of-pocket costs for health care under Medicare on demand for services from the VA system?
2.6	(4)	Does improved access to non-acute and preventive services stimulate a cost shift or reduction from one level of care to another, from one service financing system to another?

*Mean rating scores were computed from respondents identification of high (3 points), medium (2 points) and low (1 point) priority.

**Mean ranking scores were computed from respondents identification of top three questions (first choice, 3 points; second choice, 2 points; third choice, 1 point). Scores were added to determine rank.

TABLE 8

Typology Category VI: Ethical Issues

Top Rated (Four Judges) High Priority Research Questions

Mean* Rating	(Mean** Ranking)	
2.75	(2)	What changes in institutional structure and administrative methods would facilitate participation by institutionalized geriatric patients in decisions about their care?
2.75	(1)	To what degree do physicians take age into account when reaching clinical decisions?

*Mean rating scores were computed from respondents identification of high (3 points), medium (2 points) and low (1 point) priority.

**Mean ranking scores were computed from respondents identification of top three questions (first choice, 3 points; second choice, 2 points; third choice, 1 point). Scores were added to determine rank.

multi-dimensional assessment as a tool for care planning, continuity in discharge planning for acute care, the relationship between clinical findings and functional disability, the therapeutic ratio of specific interventions, and the effect of various communication methods on proper use of medications among the elderly.

The questions with the highest priority in the category of Patient and Family Barriers focused on the development and evaluation of a range of interventions that might strengthen family ties and forestall premature nursing home placement. Respondents (N=6) suggested testing models of respite care for elders in the family (temporary substitution of the burden of care by non-family providers to enhance the capacity of family members to continue to provide care) as well as the development and evaluation of combinations of services (e.g., nursing, homemakers, adult group homes) for poor and disabled individuals who may be at risk of nursing home placement. Another area of emphasis involved teaching family care givers skills and techniques for dealing with mentally impaired elders in their homes. In addition, panel members recommended research to study the effect of socio-economic status on utilization patterns in acute and long term care by elderly with comparable levels of disability.

In the Provider Barriers category several questions concerning practitioner education, enhancing geriatric/gerontological knowledge, methods for improving provider attitudes toward caring for the elderly and models of VA teaching nursing homes were highlighted by panel members (N=8). Another high priority area was research on the relative effectiveness of interdisciplinary versus multidisciplinary approaches to planning and provision of care to elderly patients. An additional area of inquiry related to geriatric health manpower and the impact of the dynamics of the VA labor market on entry and career development for staff.

All of the high priority questions in the Organizational and Systems Problems category received the same rating (N=6). The most general question addressed the issue of anticipated effects, outcomes, costs and effects on sub-groups from community-based long term care services provided by the VA. The costs and benefits of comprehensive assessment and various models of case management (care coordination) in the provisions of care to the elderly were also seen as important areas of inquiry. Further, the creation of a minimum data set to support the delivery of quality care to eligible veterans was identified as deserving attention.

Panel members (N=6) in the Policy category gave strong endorsement to a descriptive study of the utilization of various health care programs by aging veterans. Other highly rated questions included an investigation of alternative approaches for pooling VA and non-VA funding of long term care (such as funding waivers) and the effects of demand, supply, costs, and access on cost shifts among reimbursement systems and across levels of care.

Two questions in the category of Ethical Issues were rated equally highly by respondents (N=4). One addressed methods for facilitating the participation of institutionalized elders in decisions about their care and the other concerned the effect of patient's age on physician's clinical decisions.

Consensus: Agreement Between Panels A and B

This study was designed to draw upon the expertise and experience of two groups, individuals with responsibility for the delivery of care to elderly patients and researchers. Project investigators combined data from both groups to derive an empirically based research agenda regarding care for the older veteran. Panel A was asked to identify problems that are barriers to the delivery of care to elders and Panel B members wrote research questions based on a typology of the problems.

Thirteen of the 27 high priority research questions (Panel B) were within problem subcategories rated highly by Panel A (top 50% of the 19 typlogy subcategories). These questions are listed in Table 9 (p. 37). The questions fell into five of the six major typology categories; none addressed ethical issues. The questions cover a wide range of concern and reflect the breadth of issues needing systematic investigation. The overlap between Panel A's designation of important problems and Panel B's specification of high priority research questions may provide guidance regarding a research agenda with a conceptually justified basis: high priority problems and questions meaningful to clinicians and researchers.

TABLE 9

Overlap Between Panels A and B

SOCIOECONOMIC PROBLEMS OF OLDER PEOPLE (IIC)*:

What models of respite care, which do not disrupt family ties, are appropriate for families of older, confused, needy individuals?

What incentives would foster the creation of "surrogate" families for elderly individuals without families, in order to provide support and assistance and to delay or preclude inappropriate institutional placement?

Under what circumstances is shared housing in combination with supportive homemaker or live-in help a feasible living arrangement which can address the income and long term care needs of poor and disabled citizens?

What is the effect of socioeconomic status on acute and long term care utilization by aged individuals with comparable levels of health and functional impairments?

LACK OF KNOWLEDGE (IIIA):

What is the most effective way to assist practicing physicians to acquire necessary gerontological/geriatric information?

IATROGENESIS (ID):

To what degree do different methods of communication between providers and older patients reduce the incidence and/or severity of iatrogenic complications from medications?

LACK OF SUPPORT FOR PREVENTIVE HEALTH CARE, HEALTH MAINTENANCE, AND CHRONIC CARE PROGRAMS (VA):

How do veterans utilize various health care programs?

NEGATIVE ATTITUDES (IIIB):

How do alternative training programs affect the development of attitudes toward the elderly?

RESTRICTIVE ELIGIBILITY REQUIREMENTS (VC):

What alternative approaches can be developed which pool various sources of funding for long term care services (VA, Medicare, Medicaid) in order to: a) complement or supplement what are now often duplicative programs;b) assure an appropriate range of service availability to veterans in need of a full range of acute and LTC services; c) reduce fragmentation in service delivery to veterans and their spouses?

*Refers to Typology Category and Subcategory. See Appendix A.

Table 9 (continued)

LACK OF PREVENTIVE CARE (IA):

What are appropriate prevention/health maintenance (i.e., screening and counseling) activities for elderly VA patients (65 years and older)? a) what health care problems of the aging veteran can be ameliorated or prevented by early identification and treatment? b) what is the incidence/prevalence of these problems, particularly those regarding ambulatory diagnoses and "non-disease" oriented care? c) what is the impact of these problems on elderly VA patients? d) what is the accuracy, availability, acceptability, efficacy and cost of screening/counseling activities? e) what tools should be developed for identifying individuals for whom preventive services should be made available?

LACK OF COMPREHENSIVE CONTINUUM OF CARE (IVC):

Is comprehensive assessment of elderly patients a cost effective method for delivering health care services (e.g., does it result in early detection or reduce service demands)?

What effects can be expected from community based (non-institutional) long term care services provided by the VA and at what costs? a) what are the appropriate domains of expected outcomes and what are the best measures of these domains? b) how do the costs and effects differ among patient subgroups?

LACK OF CONTINUITY AND COORDINATION IN PATIENT CARE (IVA):

How do the benefits and costs of case management (care coordination) vary with changes in three domains: a) case manager (care coordinator) training, skills, caseload, resources, experience and task definition; b) case mix; c) point of intervention in the patient's health care system experience or spell of illness?

III. DISCUSSION AND RECOMMENDATIONS

A major challenge facing the VA is the development of health and social services that can better meet the needs of the rapidly increasing number of chronically-ill elderly veterans. A major premise underlying this project was that guidance for research on problems involved in the delivery of care to the aging veteran could be improved through the development of a research agenda. The goals were to develop an empirically-based list of major problems in the care of the aging veteran and research questions designed to address those problems to result in a research agenda specifying health services research priorities for the VA.

In this section of the report, a brief description of the study methods used will be followed by a discussion of the problems and research questions developed in this project. Next, we will present our recommendations for a research agenda, research strategies and designs, and for the administrative supports necessary to mount such studies. Finally, we discuss the VA's unique opportunity to engage in health services research and promote quality care for the aging veteran population.

The research approach used two modified Delphi surveys to pool judgments of VA and non-VA clinicians and researchers and develop lists of problems and research questions in order of priority. The first panel, Panel A, represented 16 different disciplines knowledgeable of geriatrics and gerontology. They generated and assigned priorities to problems encountered in the care of the aging veteran. The second panel, Panel B, were researchers with expertise in gerontology and/or health services research. These respondents developed and assigned priorities to research questions that addressed the problems in care provision developed by Panel A.

A listing of the problems that were rated by the Panel A respondents as the most important barriers to the care of the aging veteran are presented in Table 2 (p. 17). The three most important problems were:

- Emphasis by the medical care system on acute care at the expense of preventive care, rehabilitation services and health maintenance;
- Lack of financial resources needed by older people to purchase health care, social support services and therapeutic aids;
- Lack of consideration of the impact of multiple physical, social and psychological problems on the lives of older people and their day to day functioning.

These problems reflect the mismatch between dominant modes of health care service delivery and the needs of older persons. Research focusing on improvements in various aspects of the organization, financing, and delivery of care may result in solutions to such overriding problems.

The highest priority research questions developed by Panel B are presented in Tables 3-8 (pages 26 to 33). While the research questions in these tables are organized by typology category, they can also be understood through discussion of three major cross-cutting research questions. These three major questions can be described as: What is the nature of the problem? What are valid measurement strategies? What is the effectiveness of possible interventions?

What is the Nature of the Problem?

Several Panel B respondents called for descriptive surveys and epidemiological investigations. Panel B respondents called for the collection of descriptive data across VA and non-VA health care delivery systems to determine the utilization of acute and long-term care services in and outside the VA and the effect of socioeconomic status and increased out of pocket costs under Medicare. Respondents also recommended descriptive studies on the supply, demand and costs of non-acute and preventive services under varying reimbursement systems and rates. According to several Panel B members, descriptive studies should also be focused on the effects of labor market dynamics on career development among providers of geriatric care. A highly rated question on medical ethics requiring a descriptive approach concerned the degree to which physicians take age into account when reaching clinical decisions. Other questions amenable to an epidemiological approach included those concerning the relationship between clinical findings and physical dysfunction and the incidence/prevalence of chronic clinical problems that are amenable to health maintenance interventions.

What are Valid Measurement Strategies?

Valid and reliable measurement of patients' functioning and of outcome indicators in the delivery of care are fundamental to rigorous health services research. Several highly rated research areas called for the development and refinement of instruments for use in the provision of care. According to Panel B respondents, key areas for development include:

- Instruments for measuring functional, nutritional, and mental status so as to target services to sub-populations of veterans (e.g., home care, discharge planning, prevention);
- Valid and reliable measures of various outcomes in evaluative studies (e.g., cost, efficacy, therapeutic ratio, early detection, functional impairment, satisfaction, quality of life, patient acceptance, service availability);
- The minimum data set for VA medical and health services that is required to provide coordinated and continuous care to the eligible population.

What is the Effectiveness of Possible Interventions?

Many of the highly rated research questions concern testing various approaches to the provision of preventive care, community-based long term care services, and institutional care. Panel B participants suggested that research focus on the following programs or functions:

- Respite care (temporary substitution of the burden of care by non-family providers to enhance the capacity of family members to continue to provide care)
- Community-based long-term care services for non-institutionalized elderly (home care, day care, housing alternatives, informed support systems)
- Approaches to pooling various sources of funding for long-term care services (VA, Medicaid, Medicare pooling which may require waiver authority)
- Comprehensive assessment
- Case management
- Different ways of organizing teams of health care professionals in the delivery of care (interdisciplinary vs. multidisciplinary)
- Screening and counseling in preventive care
- Efforts to facilitate participation of institutionalized elderly in decisions regarding their care
- Methods for assisting physicians in gaining geriatric/gerontological knowledge
- Alternative training approaches for various providers and their effect on attitudes toward the elderly
- VA teaching nursing homes as sites for geriatric training
- Methods for teaching families various interventions to be used in caring for their mentally impaired elderly relatives at home
- Different communication techniques aimed at reducing iatrogenic complications among the elderly in the use of their medications.

The research questions developed in the present study can be compared to those resulting from an earlier attempt to develop a VA research agenda by Moran and Soumerai (10). In making this comparison, it is useful to note the differences in methodological approach. The Moran and Soumerai study involved a single, limited survey of 17 respondents in contrast to the present effort which involved two modified Delphi surveys of a total of 166 respondents. The Panel A and Panel B members represented a wider spectrum of fields than the GRECC clinician/biomedical researcher respondents in the Moran and Soumerai study. The Moran and Soumerai study resulted in 17 "suggested future research needs" in six topic areas. A comparison of the results between the two studies reveals some general agreement on topic areas. The research agenda presented in this paper, however, contains research questions that more comprehensively cover the field of aging research and are much more specific in their level of detail.

Recommendations

Research Agenda

Systematic investigation of various issues that affect the organization, financing and delivery of care to older veterans requires a well-conceived and orderly approach. This document presents research questions categorized by typology problem areas and research questions classified by general research areas. Either system of classification may be useful for the development of a research agenda. High priority research questions that overlap with important clinical problems may offer the most conceptually valid list of research topics for the immediate future. Those research questions are outlined in Table 9 (p. 37).

Research Strategies and Designs

In order to address these important questions it will be necessary to establish and follow a sequence of research activities. Since many of these research questions are at relatively early stages in development and have had empirical investigation only recently, it is important to acknowledge that research strategies for service delivery problems need to be appropriate to the stage of development of individual topic areas. A developmental strategy which is built on a sequence of research designs and methodologies that can provide increasingly useful information to policy makers is outlined in Table 10 (p. 46). The recommended sequence of research activities moves from descriptive to experimental studies. It should be noted that these steps represent a standard approach and that the development of some topics may require a different order or fewer steps. Design choices will depend on the state of the art in the specific area under investigation. The sequence of research activities includes:

1. Descriptive surveys and epidemiological investigations of populations and programs are included in the first stage. Descriptive data, either of a cross sectional or longitudinal nature, will provide baseline information on how delivery systems are presently operating and who is being served. These investigations can provide information on patterns of utilization among various patient sub-populations including data on use of both VA and non-VA services. Epidemiological studies will provide information both to identify target groups for intervention and to document intervention effectiveness.

2. For research questions that have had previous empirical analysis, information syntheses can be designed to produce state of the art assessments in specific areas. In order to maximize utility of information syntheses in geriatrics/gerontology, it is important to identify a well-conceptualized

TABLE 10

Developmental Sequence of HSR&D Projects in Geriatrics/Gerontology

SEQUENCE OF RESEARCH ACTIVITY BY TYPE	SUPPORTIVE RESEARCH
1. Descriptive Surveys and Epidemiological Investigations	Measurement Capability
2. Information Synthesis	and
3. Pilot Projects and Evaluations	
4. Demonstration Projects and Evaluations	
5. Program Implementation and Monitoring	Information Systems

group of specific research questions. Secondary data analysis, where useful and feasible, can be designed to address questions that have not been examined by previous investigators or which are of particular interest to the VA. Information synthesis is an efficient approach to gathering knowledge in health services research and can be a particularly useful activity in the implementation of a research agenda focused on the delivery of health care to older veterans.

3. Innovative programs and new approaches to the provision of services can be evaluated with pilot projects. Pilot project activities would occur in a single location and could include a range of studies from descriptive to experimental. These projects would provide an opportunity to pretest evaluative strategies including sample size determination, estimation of the magnitude and variability of program effects, testing of operational measures and identification of topics for program evaluation. Pilot efforts should require limited resources to develop and evaluate the effectiveness of the new intervention or service delivery model. Projects which appear to be promising at the pilot stage could be explored further as demonstration efforts.

4. The design and implementation of well-conceived demonstration projects is the next step in the recommended HSR&D sequence. Demonstrations would be carefully designed for implementation and testing at multiple sites within the VA system. Systematic attention to both process and outcome evaluation, will facilitate evaluation of variation among the different sites. At the demonstration stage, experimental research designs will be the norm for evaluation studies. Multi-site demonstration projects will require substantial resources to support both the services and the research, as well as enthusiastic cooperation from VA staff at various levels for successful implementation (e.g., acceptance of standard minimum admission and discharge

criteria, comparable staffing patterns, and comparable information systems). Effective and efficient demonstration programs can then be considered for larger scale implementation at multiple sites within the VA system.

5. The final developmental stage in this sequence of HSR&D activities is the dissemination and monitoring of successful programs throughout the VA system. Large scale dissemination will require careful guidance for implementation, as well as routinized methods for data collection. These data can then be used for ongoing program evaluation and monitoring purposes.

Specific projects designed to investigate long term care service delivery for older veterans will require two fundamental supports, measurement capabilities and information systems. Research in geriatrics/gerontology involves efforts to measure elusive concepts, such as functional capacity, quality of life, and patient satisfaction as well as various costs associated with the provision of care. These indicators require careful investigation based upon thorough conceptual exploration. Cost related concerns are directly related to the need for comprehensive information systems. Such systems will facilitate retrieval of necessary information and can be designed to enhance ease of access and timely turn around. Valid and reliable measurement and efficient information systems are cornerstones for research focused on the organization, financing and delivery of care.

Supports for Implementation of Research Strategy

The following administrative supports will be necessary if a systematic research strategy is to be carried out.

1. Studies focused on system change will require sanction and mandate from relevant offices in the VA system.

2. The VA should consider the development of waiver authority, perhaps requiring legislative action, which can sanction modifications in routine

financial and organizational approaches in order to test and demonstrate innovative programs. (Waivers are present in the Social Security Act for both the Medicare and Medical Assistance programs and have provided the necessary flexibility in these programs to test the efficacy of innovative service delivery models.)

3. Procedures and protocols must be developed to facilitate multi-site projects, including mechanisms for collaboration across sites and adequate travel budgets for investigators engaged in large scale multi-site research.

4. Incentives must be designed to encourage hospital administrators to develop innovative programs, modify patterns of service delivery, and participate in evaluative research.

5. Information systems based on the Long Term Care Minimum Data Set (11) should be developed so that at least basic descriptive information can be compared across programs.

6. The VA system must improve its capacity to cost out various long term care services. Currently, the VA system is severely limited in its ability to evaluate these services. HSR&D can foster the development of more valid cost measurement systems and their inclusion in all program evaluations.

7. Evaluate all new programs designed to serve the aging veteran.

8. Provide leadership in the design of collaborative research projects with providers in other community delivery systems.

Recommendations for Action

Action steps should include:

1. Dissemination of this document to aging researchers throughout the country to identify problem areas and research questions and to stimulate inquiry. Clinicians can utilize this report to be more informed about identified problems in geriatric care. Administrators would find this

document helpful in becoming familiar with problems in caring for older veterans. This document may encourage administrators to lend their support to research activities. Veterans Groups, Senate Veterans Affairs Committee and Congressional Committees on Aging should receive copies of this document for consideration. National organizations, both public and private, that are concerned with the delivery of health care to the elderly should review this report so they can be aware of its findings and recommendations.

2. Evaluation by the HSR&D office at VACO to determine the feasibility of pursuing research in highly rated areas. This requires a broad perspective and direct communication between researchers and VACO. Researchers need to evaluate feasibility in terms of scientific merit and the validity of the results. Central office staff need to consider multiple factors in assessing feasibility including financing, manpower, time requirements and priority in terms of the directions indicated in the VA's Plan for Older Veterans.

3. Issuance from the HSR&D office at VACO of special announcements and requests for proposals which address highly rated research areas.

4. Assessment of areas in which other federal agencies have supported investigation so that VA activities compliment previous research and avoid duplication.

5. Initiate and foster collaboration between various VA departments, including Geriatrics and Extended Care, and with organizations in the community.

6. Develop and fund information syntheses on topics described in this document.

7. Assess the state of the art in these topics through the application of the developmental sequence of research designs and methodologies outlined in this document.

The VA's Unique Opportunities

The VA faces an unprecedented challenge as it prepares to serve large numbers of older veterans. The VA will have to deal with this demographic imperative far sooner than other delivery systems and provide leadership in the delivery of care to elders. An examination of the high priority research questions presented in this report indicates that the majority have clear relevance to the other national delivery systems. If the VA accepts the current opportunity to address these questions, it can assume a leadership role in the development of the nation's efforts to develop a more effective and efficient long-term care system.

In some ways the VA is in a unique position to facilitate significant health services research in geriatrics/gerontology. The presence of an identifiable and potentially traceable patient population makes both prospective and retrospective studies feasible. Robert Kane has written that the VA's "network of services provides a large resource for patients. Because the whole effort is contained within a single system, it is possible to vary the way in which services are provided without withholding services from any individual" (12). Furthermore, the VA has the capacity to build on its experience in the provision of institution-based chronic care (nursing homes and domiciliaries) by moving toward innovative approaches in community care. Creative combinations of medical care services and veterans benefits programs not possible in other delivery systems may make it possible to expand the range and scope of services available to needy veterans. Further, the VA can provide leadership on the effects of prospective reimbursement and the way it influences the delivery of care.

Long term care analysts frequently point to the fragmentation of service delivery as a major problem, the gap that exists between health and social service programs. The VA is in a position to provide much needed leadership in linking the delivery of health and social services for older veterans. The VA has an unique opportunity to more fully coordinate its own medical care and benefits programs and to work collaboratively with community agencies. The provision of comprehensive services in collaboration with community providers represents a significant inter-system challenge for the VA.

Each of these issues are amenable to systematic investigation through health services research. Given the scope of the problems the VA will encounter, it is imperative that these initiatives are thoroughly studied in order to appropriately guide policy and program development.

As gerontologists and health services researchers in geriatrics, we believe that this research agenda presents state of the art questions which will lead to answers that improve care provided to aging veterans in the near and long term. The agenda incorporates considerable breadth, as demonstrated by questions that address both social and medical services. It also suggests important research questions for policy makers, such as the cost-effectiveness of various components of comprehensive services for older veterans. Recently, the VA has developed policy documents that recommend program development and system changes to accomplish coordinated and comprehensive care for older veterans through community linkages (1,2). This research agenda reflects similar directions. Health services research in these areas can provide guidance to policy makers that will facilitate successful attainment of these goals. The agenda provides useful direction and information for policy makers, program managers, researchers and clinicians.

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APPENDIX A

Typology of Problems Related to Care of the Elderly

I. Clinical Problems

A. Lack of Preventive Care. Services to help older people avoid many of the physical and psychological problems associated with old age are not readily available. Similarly, few health care professionals have on-going contact with older people for purposes of early detection and prevention of various conditions. In addition, limited attention is given to making the environment supportive of frail individuals, especially those with various sensory and/or cognitive losses.

B. Difficulties Identifying Patient Needs. Physical and psychological needs of the elderly are often undetected due to 1) difficulties obtaining clinical information, 2) lack of attention by professionals to specific problems (e.g., depression, substance abuse, social support needs), 3) the multiple and complex nature of problems, and 4) the lack of valid and reliable physical, social, and psychological assessment instruments.

C. Lack of Effective Therapeutic Intervention Programs. There is a lack of knowledge concerning the effectiveness of many interventions used with the elderly (e.g., aids for physical functioning, behavior management strategies). Additionally, in many cases there are no readily available interventions designed to meet a particular physical or emotional need.

D. Iatrogenesis. Iatrogenesis is commonly related to overprescription of psychoactive medications and polypharmacy. Non-drug-related problems also occur (e.g., inappropriate procedures and therapies, provider caused injuries, poor skin care).

II. Patient/Family Barriers

A Lack of Patient/Family Knowledge. Older people and their families need more information regarding their specific disease and more general information on health, prevention, illness in old age, self care, and medical terminology. Older people also lack knowledge on how to access services.

B. Attitudes. For a variety of reasons, attitudes of older people may serve as barriers to health care. This includes a lack of motivation for self care and failure to follow prescribed treatment. In addition, passive, withdrawn patients are unlikely to participate in their own care. Fear of dependence and nursing home placement may keep people from seeking help when it is needed.

C. Socioeconomic Problems of Older People. Many older people do not have families to provide needed support and assistance to augment available formal services. When families are present, many provide constant care to their elderly relatives, and therefore also have important needs for support services, therapies, and visits to providers are beyond the means of the elderly.

III. Provider Barriers to the Provision of Health Care

A. Lack of Knowledge. Many health professionals receive inadequate geriatric/gerontological training necessary for responding appropriately to the multiple problems of the elderly. Provider lack of knowledge regarding conditions common to and/or unique to the elderly interferes with treatment and often leads to inappropriate care and patient non-compliance.

B. Negative Attitudes. Negative attitudes include stereotyping the elderly, lack of interest, impersonal care, placing a low priority on care of elderly patients, and viewing long-term care as unstimulating, unimportant and demeaning. While all types of providers demonstrate negative attitudes, physicians' attitudes are criticized more frequently than other providers.

C. Interprofessional Relationship Difficulties. Due to the multiple problems faced by the elderly, an interdisciplinary appraoch to patient care is often required but difficult to achieve. Not only is there a lack of training in team care, but it is difficult to establish an acceptable balance in decision-making authority between non-medical and medical staff, and to identify specific professional roles and responsibilities. Similarly, conflicts between professionals, often result in underutilization of mid-level providers.

D. Management and Staffing Problems. It is difficult to recruit and retain qualified professional and non-professional staff to work with the elderly in geriatric hospital units and in long-term care facilities. In addition, there are often inadequate numbers of staff due either to recruitment problems or to staffing ceilings. Furthermore, in some cases, staff assigned to care for geriatric patients also have responsibilities for other patients with more acute problems which limits their time and ability to meet the needs of the aged. Revolving or rotating staff results is inconsistent patient care. Finally, staff morale problems inhibit quality service to the aged.

IV. Organizational and Systems Problems

A. Lack of Continuity and Coordination in Patient Care. In focusing on existing services, three issues should be considered. First, there is a poor use of manpower (e.g., case managers, interdisciplinary teams, patient advocates) in care of the aged. Similarly, the same physician and treatment staff are often not involved in different phases of care given to an elderly person. Second, there is a lack of coordination of VA services. In addition, follow-up services for VA patients are often unavailable and, in cases where such services raise ethical questions, particularly if mental competency is in question.

B. Justice and Equity in Health Care. Ethical issues involved in the care of individuals must also be considered at a more systemic macro level and include issues regarding the cost and benefit of various services--human costs as well as monetary costs--and the allocation of scarce resources.

Question: 23. What plans, if any, do you have to implement the recommendation of HSR&D (page 6-19) to encourage the use of nurse practitioners, particularly in such areas as chronic care?

Answer: We will continue to support the utilization of nurse practitioners in appropriate settings, always giving consideration to patient needs and to other care providers. Nurse practitioners are well recognized in the VA and their skills are not only utilized in chronic care, but also in other settings such as Hypertension Screening Clinics, Women's Health Clinics, and Ambulatory Care.

Question: 24. When do you expect to reach your goal (page 6-19) of having two HSR&D Field Programs in each of the VA's seven regions?

Answer: Our plans call for a gradual buildup to 2 Field Programs per region and we expect to reach that goal by 1991.

Question: 25. When will the Spinal Cord Injury (SCI) Registry have the the capability of analyzing data and trends pertaining to SCI veterans?

Answer: If the planned implementation date of October 1, 1986 is realized, the spinal cord injury registry will be capable of analyzing data trends pertaining to SCI veterans on December 1, 1988 for data that is specific to the registry.

Question: 26. Please provide a list by resources (including dollars and FTEE) that were allocated to each of the following programs or activities during fiscal years 1985 and 1986 (prior to the implementation of the Gramm-Rudman-Hollings sequestration order) and that will be allocated during Fiscal Year 1987:

- Adult Day Health Care
- Agent Orange Exams
- Aid and Attendance Services
- Alcohol and Drug Abuse Halfway House Care
- Acquired Immune Deficiency Syndrome (AIDS)
- Audiology and Speech Pathology Services
- Blind Rehabilitation Units
- Bone Marrow Transplant Services
- Cardiac Surgery Services
- Chronically Mentally Ill Halfway House Care
- Dental Care Services (VA and non-VA)
- Female Veterans Health Care Services
- Former Prisoner of War Health Care Services
- Geriatric Evaluation Units
- Geriatric Research, Education and Clinical Centers (GRECCs)
- Heart Transplant Services
- Home Health Services
- Hospital-Based Home Care
- Occupational Safety and Health Monitoring (FTEE for industrial hygiene specialists, safety engineers)
- Post-Traumatic-Disorder Units
- Prescription Drugs (inpatient, outpatient, and fee-basis)
- Preventive Health-Care Services
- Prosthetics and Sensory Aids Services
- Puerto Rico Health Care (VA and non-VA)
- Quality Assurance Programs (SERP, SIR, Risk Management, MEDIPRO)
- Readjustment Counseling (VA and non-VA)
- Regional Medical Education Centers
- Renal Transplant Services
- Sickle Cell Anemia Services
- Spinal Cord Injury Units

Answer: Not all of the thirty program/activities referenced in the question are resource monitored. An attempt was made to divide the programs into two basic categories; those programs that are normally resource monitored, and those programs that are not resource monitored. Although a few of the programs requested may impact more than one appropriation, only those resources accounted for under the Medical care appropriation are shown.

The following programs are resource monitored. Various accounting records provide us with actual 1985 obligations. Because of normal budgetary interest, estimates are normally provided in the current year (1986) and budget year (1987) for a few of these programs (HBHC, GRECC, ADHC and Readjustment Counseling). However, the unique nature of this year's budget precludes an attempt to predict the impact of budget deficit proposals on specific programs beyond the major activity level provided in the budget (page 5-42).

	1985 Actual	
Program	FTEE	$(000)
Adult Day Health Care	34	$ 1,324
GRECCs	147	7,233
Hospital Based Home Care	412	15,306
Readjustment Counseling (VA & Non VA)	727	38,687
Speech Pathology Unit	383	14,715
Blind Rehab. (Med. bed section)	304	11,105
Cardiac Surgery	626	44,290
Dental Care Outpatient Svc. (VA & Non VA)	2,177	89,144
Prosthetic Treatment	285	26,143
Puerto Rico & Virgin Island Health Care.	1,918	102,784
RMEC (direct obligations)	133	5,605
Renal Transplant Svc	114	6,314
Spinal Cord Injury (Med. bed section)	3,193	116,141
Prescription Drugs	...	503,000

Actual resources are not reported for the following:

Agent Orange Exams

Aid and Attendance Services

Alcohol & Drug Abuse Halfway House Care

AIDS

Bone Marrow Transplant Services

Chron. Mentally Ill Halfway House Care

Female Veterans Health Care Services

Former POW Health Care Services

Geriatric Evaluation Units

Heart Transplant Services

Home Health Services

OSHA

Post-Traumatic-Disorder Units

Preventive Health - Care Services

Quality Assurance

Sickle Cell Anemia Services

Question: 27. Your MAMOE budget (page 7-3) for fiscal year 1987 shows a decrease of 73 FTEE from the fiscal year 1986 estimate. You indicate that postgraduate and inservice training activities are being transferred to the medical care account and that facility planning activities are being transferred to the minor construction account.

a. How many FTEE are being transferred with each activity?

Answer: Seventy-three (73) FTEE with the facility planning activities. No FTEE with postgraduate and inservice training activity.

Question: b. Will the remaining 591 FTEE be adequate for you to monitor the medical centers performance regarding the quality of care they provide and the efficiency with which they provide it?

Answer: With the FY 1987 budget, MAMOE will have accommodated dramatic reductions. Operations have been streamlined, workload with a low priority has been eliminated, and selected functions have been delegated to the field. However, monitoring the quality and efficiency of health care delivery is a high priority management initiative and additional funds of $3,339,000 have been requested in Medical Care and $50,000 in MAMOE in support of this initiative. The limit of constructive restructuring of Central Office operations has been reached.

VA MEDICAL FACILITY CONSTRUCTION

Question: 1. The Augusta VA Medical Center replacement project has been downsized from the original proposal.

a. What specific policy guidelines and methodology were used to downsize the Augusta project?

Answer: The Augusta project was downsized based on the declining Lengths of Stay which have been occuring in the VA system in the recent past.

Question: b. What, if any, changes in VA medical facility construction program policy and/or the VA-GAO bed-sizing methodology have been or will be implemented to reflect the general policies and methodologies used in sizing the Augusta project?

Answer: The VA has recently completed revisions to the VA-GAO bed-sizing methodology which will incorporate recent experience based on Diagnosis Related Groups (DRG). By incorporating these recent data into the bed-sizing methodology, projections of future bed demand will take into account the decreasing lengths of stay which many VA medical centers have been experiencing due to the application of DRGs. These bed-sizing results will be used to size future construction projects.

QUESTION:

2. Please provide the current funding and award schedules for the replacement projects at VA medical centers Augusta, GA and Baltimore, MD. Please include schedule and current estimated cost of the following:

(a) A/E Preliminary Award (All Phases)
(b) Preliminary Completion (All Phases)
(c) Working Drawing Award (All Phases)
(d) Working Drawing Completion (All Phases)
(e) Construction Awards (All Phases)
(f) Completion of All Construction and Total Cost

Response:

Augusta, GA

(a) A/E Preliminary Award - 06/83
(b) Preliminary Completion - 11/83
(c) Working Drawing Award - 12/84
(d) Working Drawing Completion - 08/86
(e) Construction Awards: Phase I - 08/85
Phase II - 11/86
(f) Completion of All Construction and Total Cost - 01/91 $97.0 Million

Baltimore, MD

(a) A/E Preliminary Award - 04/78
(b) Preliminary Completion - 10/79
(c) Working Drawing Award - 04/78
Redesign Award - 03/86
(d) Working Drawing Completion - 02/81
Redesign Completion - 03/87
(e) Construction Awards: Phase I - 07/87
Phase II - Phasing not determined
(f) Completion of All Construction and Total Cost - 10/90 $121 Million

QUESTION:

3. What is the design schedule for the other projects on the "List of Medical Centers Currently Judged Most in Need of Construction, Replacement or Major Modernization?"

Response:

	AWARD	COMPLETE
Houston, TX		
All Phases	03/85	
Phase I (Earthwork, Foundations, Framing)		12/85
Phase II (Remainder of Building)		09/86
Phase III (Demo., Landscape, Ren. B. 206)		09/86
Phase IV (Ren. B. 7 & 211)		06/86
Mountain Home, TN	10/84	06/88
Philadelphia, PA	03/85	12/86
Allen Park, MI	04/87	12/88
Pittsburgh (AD), PA	10/87	12/88
Gainesville, FL	10/87	12/88
Palm Beach, FL	10/88	04/91
Dallas, TX	10/87	09/88

NOTE: All working drawing awards beyond FY 1987 are subject to revision due to planning improvements, changing medical program needs.

Question: 4. What plans, if any, do you have to use a prioritization methodology for proposed projects for which advance planning funds would be used?

Answer: It is our intention to use the recently developed prioritization methodology for all major construction projects. When a project is initially identified for consideration and planning purposes, the project will be scored using the methodology to assess its relative importance against all other projects. This will be a determining factor for the selection of projects to enter the Advance Planning Fund process. A final review by senior management is made to insure that other factors not addressed by the methodology are considered in establishing the final Agency priority.

QUESTION:

5. Please provide a list by project, VA Medical Center, and amount of all construction project reprogrammings for fiscal year 1986.

Response:

APPROVED FY 1985 AND FY 1986 REPROGRAMMINGS THROUGH 02/14/86

PROJECT	VA MEDICAL CENTER	AMOUNT
Replace Medical Center	Bronx, NY	$ 250,000
Air Conditioning	Coatesville, PA	3,796,000
Emergency Generator	Houston, TX	524,000
Replace Medical Center	Martinsburg, WV	860,000
Outpatient, Clinical Addition	Pittsburgh, PA	389,000
Ambulatory Care, Laboratory Addition, Research & Education	Salt Lake City, UT	3,689,000
Outpatient Addition, Electrical	Shreveport, LA	1,070,000
60-Bed Nursing Home Care Unit	St. Louis, MO	2,943,000
Clinical Addition, New Ambulatory Care	St. Louis, MO	1,093,000
Clinical Expansion	Temple, TX	1,500,000
Building 207, East Wing	Togus, ME	400,000
Clinical Addition for Laboratory	Tucson, AZ	755,000
Clinical Addition for Laboratory	Tucson, AZ	520,000
120-Bed Nursing Home Care Unit	West Los Angeles, CA	1,500,000

REPROGRAMMINGS PENDING CONGRESSIONAL APPROVAL

PROJECT	VA MEDICAL CENTER	AMOUNT
Research Addition	Long Beach, CA	$ 236,000
Outpatient Addition	Muskogee, OK	107,000
Expand Clinical, Outpatient and Educational Space	New Orleans, LA	390,000
Ambulatory Care, Laboratory Addition, Research & Education	Salt Lake City, UT	280,650

QUESTION:

6. Last year the Congress deleted several construction proposals for parking facilities because they were of low priority, especially in view of the need to increase the medical care appropriation. Your fiscal year 1987 budget includes funds for parking facilities in the projects at Augusta, Baltimore, Dayton, North Chicago, Salem, and Salisbury.

(a) How much of the total project cost is for the parking portion in each project?

(b) 38 U.S.C. 5009 (b) gives VA authority to charge parking fees and contract for the operation of parking facilities. Have you ever used this authority? Do you plan to use it (more)?

(c) How many projects already authorized but not in the final design (working drawing) phase include parking facilities? How much money could be saved by deleting the parking facilities from these projects?

Response:

(a) In five of the six projects cited, surface parking is proposed to provide for both displaced and new spaces. Only one, the Baltimore Replacement Medical Center, provides for an actual parking structure. The following indicates the numbers of displaced and new spaces and the estimated cost of same.

Augusta Replacement Medical Center - The project will provide approximately 920 parking spaces, at a cost of $730,000 out of the total estimated project cost of $97,000,000, including the 663 spaces displaced by the new construction.

Baltimore Replacement Medical Center - Parking for approximately 674 cars, at a cost of $10,000,000 out of the total estimated project cost of $121,000,000, will be accommodated in a three-level underground parking garage. This garage is an integral part of the hospital building structure.

Dayton Bed Replacement and Modernization - It is planned through this project to replace the 223 parking spaces, at a cost of $300,000 out of the total estimated project cost of $84,000,000, which will be eliminated through the new construction and relocate a number of spaces which will be required near or adjacent to the acute care medical complex.

North Chicago Environmental Improvements, Patient and Nursing Home Care Buildings - This project will eliminate approximately 238 spaces; 22 parking spaces will be relocated for handicapped parking. An additional 196 parking spaces will be added adjacent to Building 133 and the new clinical addition. The cost for parking is $430,000 out of the total estimated project cost of $92,000,000.

Salem Outpatient, Clinical, and Nursing Unit Addition - A total of 402 parking spaces will be lost due to construction. Another 266 spaces will become inaccessible due to centralization of activities around the new addition. The project design includes 416 new parking spaces, at a cost of $310,000 out of the total estimated project cost of $66,300,000, and proposed continued use of 740 spaces.

Salisbury Geropsychiatric Building - This project will result in a loss of parking spaces and the addition of 138 parking spaces, at a cost of $120,000 out of the total estimated project cost of $19,000,000.

(b) No. However, at the direction of the Senate Appropriations Committee (Senate Report 99-129), we have begun the exploration of a program through which parking facilities can be provided at medical center sites and the cost paid for or amortized by the charging of user fees. This study has not yet been concluded.

It should be noted that Section 5009(b) authorizes the VA to charge parking fees and contract for the operation of parking facilities. However, Section 5009(c)(1) specifically provides that amounts appropriated by the Congress as well as fees collected from employees shall be administered as a revolving fund to effectuate the provisions of Section 5009, "but only to the extent provided for in appropriation acts." The VA maintains the position that appropriation act language is necessary to activate the revolving parking fund, and in the absence of such enactment, the VA is without authority to impose parking fees.

(c) There are two projects already authorized but not in the final design (working drawing) phase which provide parking. They are identified below, along with the estimated cost for the parking.

Allen Park Replacement Medical Center - Up to approximately 2,300 parking spaces, dependent on alternative selected, will be provided in this project at a total estimated cost of $13,100,000.

Amarillo 120-bed Nursing Home Care Unit - A total of 118 parking spaces (53 replacement), at a total estimated cost of $190,000, will be provided in this project.

OFFICE OF THE INSPECTOR GENERAL

QUESTION 1. Please provide a breakdown of all IG employees for fiscal years 1985, 1986 and 1987 by major areas of responsibility.

ANSWER

	IG FTEE		
Area of Responsibility	1985	1986 1/	1987 1/
Immediate Office of IG	5	4	4
Investigations	75	75	75
Audit	262	260	258
Policy, Planning and Resources	43	45	44
TOTAL	385	384	381 2/

1/ Staffing levels among OIG Divisions are continually reviewed and adjusted as workload dictates.

2/ Estimated FTEE at currently approved funding levels.

QUESTION 2. Please provide information on how you intend to implement section 204 of Public Law 99-166, including the resources (FTEE and dollars) you intend to allocate for this purpose.

ANSWER Since the passage of Public Law (PL) 99-166, the Office of Inspector General has been carefully evaluating various alternatives for implementing the responsibility of monitoring the DM&S quality assurance program. In our opinion, to fully comply with the intent of PL 99-166, the Office of Inspector General will need access to independent medical expertise. Our evaluation process, which is still on-going, is focusing on the best method(s) of obtaining this medical expertise.

The monitoring of the quality assurance program is a new responsibility for which the Office of Inspector General has not been provided additional funding. Implementation of this responsibility will require trade-offs in coverage in some other area of our responsibility. Until we determine the best method(s) of fully implementing this responsibility, we cannot accurately estimate its impact on resources (FTEE and dollars).

Despite the problems in fully implementing PL 99-166, the Office of Inspector General has made a concerted effort to step up its audit coverage of the quality assurance area. For instance, in the last IG Semiannual Report, we cited opportunities for improvements in the medical care quality assurance program through (1) improved internal controls over health care providers' licenses, (2) enhanced medical risk management, and (3) better use of patient outcome analysis. We are continuing our reviews in the quality assurance area during this reporting period.

DEPARTMENT OF VETERANS' BENEFITS

1. QUESTION: Studies have shown that the Department of Veterans' Benefits (DVB) pays high rent for its space in both private and GSA managed buildings. These studies also show that DVB can recover substantial long term savings by collocating its regional offices to the grounds of VA Medical Centers in the same or nearby communities. How many Department of Veterans' Benefits regional offices are now collocated with VA Medical Centers?

RESPONSE: There is one collocated Department of Veterans Benefits Regional Office at Milwaukee, Wisconsin. The regional office is collocated on the grounds of the Wood, Wisconsin VA Medical Center. With the exception of both organizations occupying VA land and buildings at one location, they are separate entities with distinct missions. Their proximity allows a concentric segment of veterans and beneficiaries having business with each organization to avail themselves of the diverse services offered by the Department of Veterans Benefits and Department of Medicine and Surgery in a "one-stop service" operation.

This is similar to, yet distinct from, the VAMRCC (VA Medical Center and Regional Office) organization employed at 9 locations nationally. VAMROC's are managed by a single Director, who is assigned the responsibility and authority for station operations by both the Chief Benefits Director and Chief Medical Director. Generally, the scale of Agency operations permits a wider span of control for the management teams at these locations than does the larger scale operations under consideration as collocated organizations. Collocated organizations require separate management teams and operations to provide an adequate delivery system of Agency administered programs to our clientele. The VAMROC's are:

Cheyenne, Wyoming
Fargo, North Dakota
Fort Harrison, Montana
San Juan, Puerto Rico
Sioux Falls, South Dakota
Togus, Maine
White River Junction, Vermont
Wichita, Kansas
Wilmington, Delaware

2. QUESTION: How many additional regional offices will be collocated by the end of fiscal year 1987?

RESPONSE: None, however we are considering collocating VARO Little Rock in early 1988 into an existing building at the medical center site, if we determine the total benefit assessment to be favorable to the Agency and the Government as a whole.

3. QUESTION: For how many regional offices have you evaluated the costs and benefits of collocating to the grounds of a medical center?

RESPONSE: OMB Circular A-104 studies are being conducted at 5 locations.

4. QUESTION: What were the results of these collocation evaluations?

RESPONSE: Preliminary evaluations are favorable in the majority of cases. Overall benefit assessment is continuing.

5. QUESTION: Which offices were evaluated? What are the costs and savings associated with each studied collocation?

RESPONSE: OMB Circular A-104 studies are being conducted for the following stations: Wichita, Kansas; Fargo, North Dakota; Des Moines, Iowa (VAMC Des Moines and VAMC Knoxville); Little Rock, Arkansas and Houston, Texas.

Overall benefit assessment is continuing. This includes evaluation of direct construction costs and indirect benefits and offsets to current operating costs that will permit decisions to be made on each project in total.

6. QUESTION: Why were funds for additional collocation not included in the 1987 budget request?

RESPONSE: As noted above, OMB Circular A-104 studies are in progress. Information regarding the cost-effectiveness of all these projects was not available at the time of the development of the 1987 budget request.

Question:

7. In the last year the Department of Veterans Benefits was unable to print regulations, manuals changes and circulars. At the same time the VA was printing slick paper, illustrated public relations publications such as the "Vanguard", "The Year in Brief", the "VA in 1984" and others. What priority system is used to allocate printing funds when funds are scarce?

Response:

7. In March 1985 the VA established a Printing Review Board in an effort to more effectively manage limited printing funds. The Board functions in an oversight capacity insuring that all printing requests meet Agency goals and priorities.

As to the specific issue of DVB printing requirements during last year's period of scarce printing funds, several actions were taken to deal with the situation. For example, DVB established priorities for the different types of material to be procured. (See response to 8(b).) Items such as forms, form letters and envelopes, the basic needs for application and claims development, were assigned the highest priority. Pamphlets and other information type material were assigned a lower priority. Last year when the Agency moratorium was announced, DVB had a very limited amount of printing money remaining. Through the establishment of an Agency Printing Review Board, an attempt was made to prioritize requirements on an Agency level. Because of the current reduction of funds, DVB has again established priorities for the Department's printing needs.

As for specific publications, those cited such as VAnguard have also been reviewed and cut back. For example, VAnguard was cut from 16 to eight pages and distribution made only eight times per year vice 12. Also total numbers of copies printed has gone from 100,000 to 79,000 last year and has been further reduced this year to 50,000.

Question:

8. (a) Is there one printing budget for the whole Agency? Please provide the printing budget for FY 1984-1987; broken down to indicate each service's and office's allocation.

(b) Are printing allocations determined by workload, public relation demands or what?

Response:

(a) Printing and reproduction funds are budgeted separately for each department. The Office of Administration budgets for printing costs for all General Operating Expenses staff offices, based on their requests, except for the Office of Data Management and Telecommunications. The attached table provides a breakdown of printing costs, by department and staff office, for 1984 through 1987.

The printing budget breakdown by department and staff office is attached.

VETERANS ADMINISTRATION PRINTING
(dollars in thousands)

Staff Office	FY 1984 Obligations	FY 1985 Obligations	FY 1986 Current Est.	FY 1987 Cong. Estimate
Office of the Administrator	$29.4	$44.3	$16.8	$40.2
ADA for Congressional and Intergovernmental Affairs	2.4	1.1	2.0	1.7
Board of Contract Appeals	.8	.7	.1	.5
Equal Opportunity	19.5	12.0	15.0	23.1
Board of Veterans Appeals	58.5	33.9	41.2	51.0
Public and Consumer Affairs	602.2	397.8	269.0	630.0
ADA for Management	---	---	---	2.5
General Counsel	89.9	86.3	53.4	88.0
Information Management & Statistics	183.5	168.8	115.1	164.0
Personnel and Labor Relations	377.9	189.5	281.3	343.6
Office of Administration	186.1	67.7	99.8	135.4
Inspector General	33.1	46.8	37.3	46.3
Budget and Finance	132.7	111.4	116.1	153.2
Program Analysis and Evaluation	5.9	7.2	11.9	15.0
Office of Data Management and Telecommunications	1,099.1	189.9	1,211.0	1,363.0
Department of Veterans Benefits	4,259.2	2,866.7	2,738.0	4,000.0
Department of Memorial Affairs	131.1	65.3	86.0	69.0
Department of Medicine and Surgery	8,227.0	9,098.0	9,467.0	10,137.0
Office of Construction	310.0	278.0	250.0	340.0
	$15,748.3	$13,665.4	$14,811.0	$17,603.5

(b) Printing allocations and priorities, on an Agency-wide basis, are determined by the effect the printing project(s) will have upon the Agency's ability to meet its mission.

For example, within DVB, priorities are established to maintain the delivery of benefits. The Department's priorities are as follows:

(1) Forms - Includes applications and all processing documents required to deliver benefits.
(2) Field spending - Includes mandatory purchases of envelopes necessary for the operation of the benefits program.
(3) CFR/Federal Register/VA Regulations - Mandates placed on DVB by legislation and interpretations by OMB require continuing expenditures for publishing and printing of 38 CFR and Federal Register announcements. VA regulations must be printed to reflect these changes.
(4) Specialty envelopes - Required for special programs such as the Eligibility Verification Report.
(5) Directives (manuals, circulars, interim issues) - Used to implement legislative changes, OMB decisions and direct operations.
(6) Informational-type materials (pamphlets, training guides, handbooks, newsletters, memorandums, etc.) - Used to inform public of available benefits, advertise sale of VA properties and maintain communications with our constituency including lenders, brokers, schools, veterans' employers, rehabilitation community, veterans and their dependents and beneficiaries. Without funding restrictions, the effective operation of a benefits delivery program determines the amount of printing and binding funds needed.

Question:

9. Will VA again face a moratorium on printing regulations, manuals and circulars in 1986 and 1987? What is the effect of such a moratorium on the delivery of service to veterans?

Response:

9. Although printing funds are limited, we do not anticipate an Agency-wide printing moratorium in FY 1986 or 1987. Based on our discretion to manage the sequestion pursuant to PL 99-177, the Agency has chosen to considerably reduce FY 1986 printing funds. Some impact will be seen in amount of funds spent for information-type material such as pamphlets, etc. By implementing this and other conservation measures including the suspension of some VADS (Veterans Assistance Discharge System) mailings from the Austin Data Processing Center, DVB will be able to provide the basic requirements for delivery of benefits. FY 1987 projections indicate normal operations and call for adequate fundings for printing of all types of material.

QUESTION 10: The FY 1987 budget includes a proposal to terminate enrollments in the "New GI Bill" effective October 1, 1986. The "New GI Bill" was established as a pilot program and will end automatically after three years if the Congress takes no action. How much of the three year test will have run on October 1st? Do you feel this is an adequate period to evaluate the effectiveness of the program?

RESPONSE: Fifteen months of the "New GI Bill" will have run on October 1, 1986. This length of time is comparable to the length of previous education benefit test programs. The Department of Defense has had extensive experience in evaluating these previous programs.

QUESTION 11: Do you know of any evidence indicating the "New GI Bill" is ineffective as a readjustment benefit or a recruiting incentive?

RESPONSE: First of all, the New GI BIll was established in significant part to aid in the recruitment and retention of individuals in the All-Volunteer Force. The law requires DOD to formally submit a report to Congress evaluating the program's impact on recruitment and retention and whether the program is necessary for "maintaining adequate levels of well qualified active duty personnel in the Armed Forces." It is our understanding that DOD has submitted information which concludes that this is not a cost-effective approach to attracting qualified personnel to the military.

QUESTION 12: Was the opinion of the VA sought prior to the decision to terminate the "New GI Bill"? If so, what advice did you give concerning that decision?

RESPONSE: The law directs DOD to make recommendations on the effectiveness of the New GI Bill. The decision to close enrollments in the New GI Bill, effective October 1, 1986, was made during DOD's budget process.

AUTOMATED DATA PROCESSING

QUESTION: 1. Will budget reductions affect the progress of the installation of modules for the Decentralized Hospital Computer Program (DHCP), or the acquisition of hardware necessary to enhance the DHCP? How will ADP .900 Limitation Apportionment funds, already sequestered by OMB for VA ADP hardware purchases, be affected by the budget reduction?

ANSWER: To date, budget reductions have not affected the progress of the installation of modules for the Decentralized Hospital Computer Program (DHCP) and ADP .900 funds will not be reduced as a result of sequested funds. Additional funds in FY 1986 ($6,245,000) have been provided for the acquisition of DHCP hardware and FY 1987 budget requests ($36,074,000) for DHCP hardware have been submitted.

QUESTION

2. How much of the WANG office automation contract funding has been used to date? What is the disposition of the balance of that contract, and does the VA anticipate any other uses for that contract beyond office automation equipment and software (for example, does the VA plan to use that contract to obtain hardware for ADP applications other than office automation)?

ANSWER:

2. There was not any funding allocated for the office automation contract, per se. The contract is for an "indefinite quantity, indefinite delivery" of equipment, software, and services. Various VA offices must obtain funding separately and then use the contract for their individual case. The contract was awarded on December 7, 1984. The VA can acquire equipment (hardware and software) using the contract for a period of 5 years from the date of contract award. The VA can acquire services (maintenance and training, consulting, etc) using the contract for a period of 10 years from the date of contract award. To date, VA offices have ordered against this contract a purchase equivalent value of $17 million, which exceeds the minimum order quantity of $2.5 million.

The VA does not anticipate use of this contract to meet its large scale data processing needs. In fact, the hardware available under this contract is oriented toward the automation of office tasks, and does not readily lend itself to large scale data processing.

QUESTION 3: How many FTEE are currently devoted to DHCP operations as programmers/program analysts, and what is the VA's budget for these FTEE positions? Please submit a hospital-by-hospital listing of the number of DHCP-ADP personnel on site at each hospital.

ANSWER: The latest estimate of FTEE currently devoted to DHCP operations is 562. Of these, 182 are assigned to the six Regional Information Systems Centers (ISC's) as follows:

Region 1	Albany	24
Region 2	Washington	29
Region 3	Birmingham	22
Region 4	Hines	*41
Region 5	Salt Lake City	26
Region 6	San Francisco	40
	Total	**182

*Includes 10 FTEE devoted to Medical District 17 COMISS operations.

** Number includes all clerical, administrative, and programmer/analysts.

The majority of the ISC staffs are involved in DHCP applications development as programmers/program analysts. The primary function of the remaining estimated 380 FTEE located at the VA Medical Centers is DHCP site management and operations. The detailed list of DHCP Field Station Staffing is attached.

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                          DHCP FIELD STATION STAFFING  FEB 24,1986  12:04    PAGE 1
                                                         PAY &
REG-DIST-STA.NO.          STATION NAME          FTEE   BENEFITS
----------------------------------------------------------------------------------

  1-01-402                TOGUS                  4.0     115379
  1-01-405                WHITE RIVER JCT        2.0      57689
  1-01-518                BEDFORD                4.0     115379
  1-01-523                BOSTON                 4.0     115379
  1-01-525                BROCKTON               3.0      86534
  1-01-608                MANCHESTER             3.0      86534
  1-01-631                NORTHAMPTON            2.0      57689
  1-01-650                PROVIDENCE             4.0     115379
  1-01-750                BOSTON OPC             2.0      57689
  1-02-500                ALBANY                 6.0     173068
  1-02-513                BATAVIA                1.0      28845
  1-02-514                BATH                   3.0      86534
  1-02-528                BUFFALO                4.0     115379
  1-02-532                CANANDAIGUA            3.0      86534
  1-02-670                SYRACUSE               3.0      86534
  1-03-455                SAN JUAN               4.0     115379
  1-03-526                BRONX                  3.0      86534
  1-03-527                BROOKLYN               6.0     173068
  1-03-533                CASTLE POINT           2.0      57689
  1-03-620                MONTROSE               2.0      57689
  1-03-627                NEWINGTON              2.0      57689
  1-03-630                NEW YORK               7.0     201913
  1-03-632                NORTHPORT              4.5     129801
  1-03-689                WEST HAVEN             2.5      72112
  1-03-790                NEW YORK OPC           0.0          0
  2-04-460                WILMINGTON             2.0      57689
  2-04-542                COATSVILLE             2.0      57689
  2-04-561                EAST ORANGE            3.0      86534
  2-04-595                LEBANON                1.0      28845
  2-04-604                LYONS                  1.0      28845
  2-04-642                PHILADELPHIA           0.0          0
  2-04-693                WILKS BARRE            1.0      28845
  2-05-503                ALTOONA                2.0      57689
  2-05-529                BUTLER                 2.0      57689
  2-05-540                CLARKSBURG             1.0      28845
  2-05-562                ERIE                   1.0      28845
  2-05-645                PITTSBURGH H D         2.0      57689
  2-05-646                PITTSBURGH U D         2.0      57689
  2-06-512                BALTIMORE              2.0      57689
  2-06-566                FT. HOWARD             2.0      57689
  2-06-613                MARTINSBURG            2.0      57689
  2-06-641                PERRY POINT            1.0      28845
  2-06-688                WASHINGTON             3.0      86534
  2-07-517                BECKLEY                1.0      28845
  2-07-581                HUNTINGTON             2.0      57689
  2-07-590                HAMPTON                2.0      57689
  2-07-652                RICHMOND               3.0      86534
  2-07-658                SALEM                  2.0      57689
  2-08-558                DURHAM                 2.0      57689
  2-08-565                FAYETTEVILLE NC        2.0      57689
  2-08-621                MOUNTAIN HOME          1.0      28845
  2-08-637                ASHVILLE               2.0      57689
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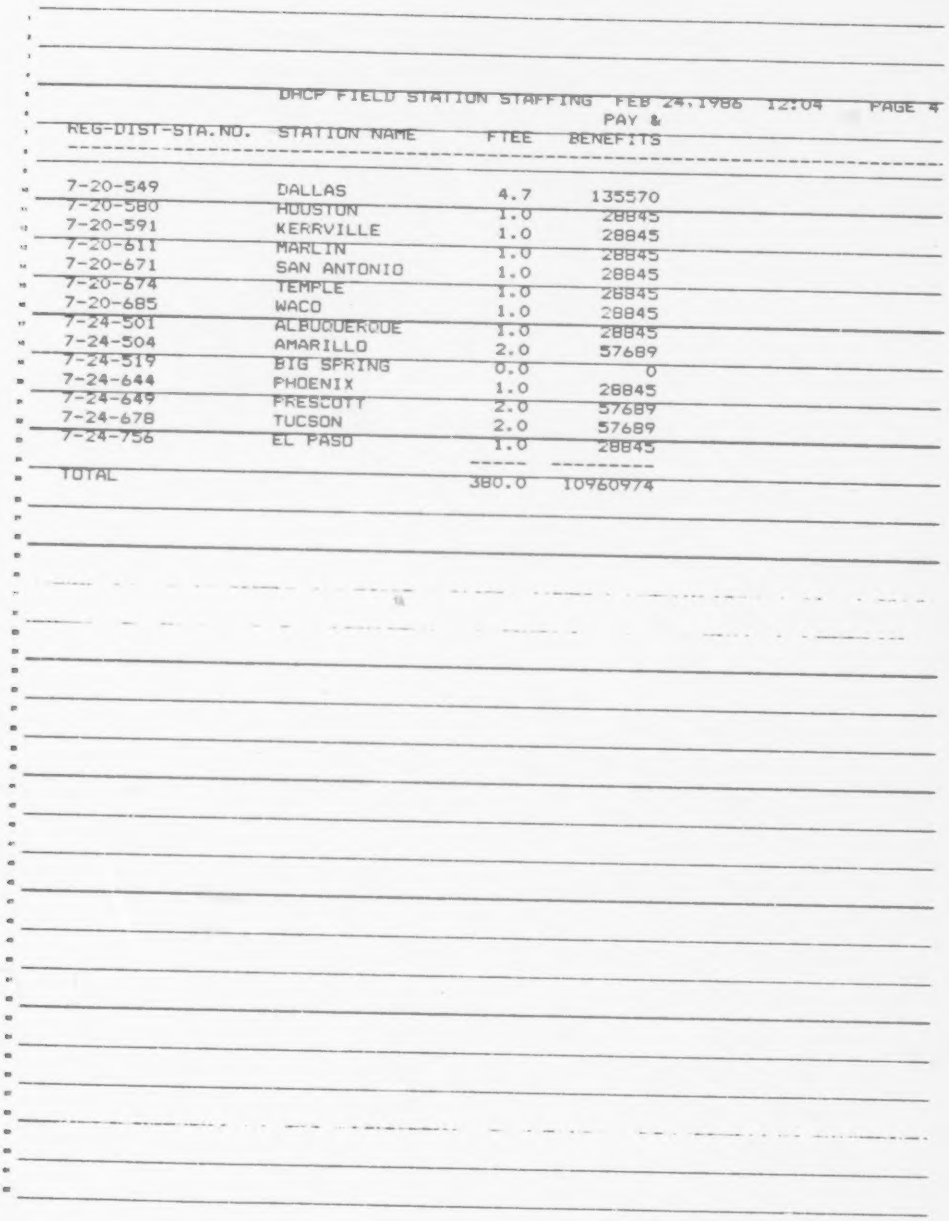
DRCP FIELD STATION STAFFING FEB 24,1986 12:04 PAGE 2

REG-DIST-STA.NO.	STATION NAME	FTEE	PAY & BENEFITS
2-08-659	SALSBURY	1.0	28845
3-09-508	DECATUR	2.0	57689
3-09-509	AUGUSTA	2.0	57689
3-09-534	CHARLSTON SC	2.0	57689
3-09-544	COLUMBIA SC	0.0	0
3-09-557	DUBLIN	1.0	28845
3-10-423	JACKSON	2.0	57689
3-10-520	BILOXI	2.0	57689
3-10-521	BIRMINGHAM	3.0	86534
3-10-619	MONTGOMERY	1.0	28845
3-10-679	TUSCALOOSA	2.0	57689
3-10-680	TUSKEGEE	1.0	28845
3-11-596	LEXINGTON	2.0	57689
3-11-603	LOUISVILLE	2.0	57689
3-11-614	MEMPHIS	2.0	57689
3-11-622	MURFREESBORO	2.0	57689
3-11-626	NASHVILLE	2.0	57689
3-12-516	BAY PINES	2.0	57689
3-12-546	MIAMI	4.0	115379
3-12-573	GAINSVILLE	3.0	86534
3-12-594	LAKE CITY	2.0	57689
3-12-6[illegible]	TAMPA	3.0	86534
4-13-5[illegible]	CHILLICOTHE	[illegible]	86534
4-13-5[illegible]	CINCINNATI	[illegible]	[illegible]15379
4-13-541	CLEVELAND	2.0	57689
4-13-552	DAYTON	2.0	57689
4-13-757	COLUMBUS	2.0	57689
4-14-506	ANN ARBOR	3.0	86534
4-14-515	BATTLE CREEK	3.0	86534
4-14-553	ALLEN PARK	4.0	115379
4-14-655	SAGINAW	0.0	0
4-15-550	DANVILLE	1.0	28845
4-15-569	FT. WAYNE	1.0	28845
4-15-583	INDIANAPOLIS	3.0	86534
4-15-609	MARION ILL.	1.0	28845
4-15-610	MARION IND.	2.0	57689
4-16-585	IRON MOUNTAIN	2.0	57689
4-16-607	MADISON	3.0	86534
4-16-676	TOMAH	3.0	86534
4-16-695	WOOD	4.0	115379
4-17-535	CHICAGO LS	2.0	57689
4-17-537	CHICAGO WS	3.5	100956
4-17-556	NORTH CHICAGO	2.0	57689
4-17-578	HINES	5.0	144224
5-18-437	FARGO	1.0	28845
5-18-438	SIOUX FALLS	2.0	57689
5-18-618	MINNEAPOLIS	8.0	230758
5-18-656	ST. CLOUD	1.0	28845
5-21-452	WICHITA	2.0	57689
5-[illegible]-5[illegible]	COLUMBIA MO	[illegible]	[illegible]768[illegible]
5-21-589	KANSAS CITY	3.[illegible]	86534
5-21-647	POPLAR BLUFF	2.0	57689

DHCP FIELD STATION STAFFING FEB 24,1986 12:04 PAGE 3

REG-DIST-STA.NO.	STATION NAME	FTEE	PAY & BENEFITS
5-21-657	ST. LOUIS	3.0	86534
5-21-677	TOPEKA	2.0	57689
5-21-686	LEAVENWORTH	2.0	57689
5-22-555	DES MOINES	2.0	57689
5-22-568	FT. MEADE	2.0	57689
5-22-574	GRAND ISLAND	1.0	28845
5-22-579	HOT SPRINGS	2.0	57689
5-22-584	IOWA CITY	4.0	115379
5-22-592	KNOXVILLE IOWA	2.0	57689
5-22-597	LINCOLN	2.0	57689
5-22-636	OMAHA	1.0	28845
5-23-436	FT. HARRISON	1.0	28845
5-23-442	CHEYENNE	1.0	28845
5-23-554	DENVER	4.0	115379
5-23-567	FT. LYON	1.0	28845
5-23-575	GRAND JUNCTION	1.0	28845
5-23-617	MILES CITY	1.0	28845
5-23-660	SALT LAKE CITY	4.0	115379
5-23-666	SHERIDAN	1.0	28845
5-23-791	DENVER VAPC	0.0	0
6-25-600	LONG BEACH	3.3	95188
[illegible]-605	LOMA LIN[illegible]	[illegible]	[illegible]73[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
6-25-665	SEPULVEDA	4.0	[illegible]
6-25-691	WADSWORTH	3.5	100956
6-25-752	LOS ANGELES OPC	0.0	0
6-25-758	LAS VEGAS	1.0	28845
6-26-359	HONOLULU	0.5	14422
6-26-388	MINILA	0.0	0
6-26-570	FRESNO	2.0	57689
6-26-599	LIVERMORE	2.0	57689
6-26-612	MARTINEZ	4.5	129801
6-26-640	PALO ALTO	4.0	115379
6-26-654	RENO	1.0	28845
6-26-662	SAN FRANCISCO	8.0	230758
6-27-363	ANCHORAGE	2.0	57689
6-27-505	AMERICAN LAKE	2.0	57689
6-27-531	BOISE	1.0	28845
6-27-648	PORTLAND	3.0	86534
6-27-653	ROSEBURG	2.0	57689
6-27-663	SEATTLE	1.0	28845
6-27-668	SPOKANE	1.0	28845
6-27-687	WALLA WALLA	2.0	57689
6-27-692	WHITE CITY	2.0	57689
7-19-502	ALEXANDRIA	1.0	28845
7-19-564	FAYETTEVILLE AR	2.0	57689
7-19-598	LITTLE ROCK	3.0	86534
7-19-623	MUSKOGEE	1.0	28845
7-19-629	NEW ORLEANS	2.0	57689
7-[illegible]-635	OKLAHOMA CITY	[illegible]	[illegible]
7-19-667	SHREVEPORT	1.0	28845
7-20-522	BONHAM	1.0	28845



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                       DHCP FIELD STATION STAFFING  FEB 24,1986  12:04    PAGE 4
                                                          PAY &
REG-DIST-STA.NO.       STATION NAME         FTEE      BENEFITS
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7-20-549               DALLAS                4.7        135570
7-20-580               HOUSTON               1.0         28845
7-20-591               KERRVILLE             1.0         28845
7-20-611               MARLIN                1.0         28845
7-20-671               SAN ANTONIO           1.0         28845
7-20-674               TEMPLE                1.0         28845
7-20-685               WACO                  1.0         28845
7-24-501               ALBUQUERQUE           1.0         28845
7-24-504               AMARILLO              2.0         57689
7-24-519               BIG SPRING            0.0             0
7-24-644               PHOENIX               1.0         28845
7-24-649               PRESCOTT              2.0         57689
7-24-678               TUCSON                2.0         57689
7-24-756               EL PASO               1.0         28845
                                           -----     ---------
TOTAL                                      380.0      10960974
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Question 4: Please submit a complete ADP budget account, breaking out DVB, DM&S, ODM&T and Central Office FTEE devoted to ADP development, programming, and management. This list should include all FTEE, total salaries, and costs of outside contracts, proposed hardware costs, and the to-date cost of DHCP.

ADP BUDGET ACCOUNT
(dollars in thousands)

ADP BUDGET	1/ DM&S	DVB	ODM&T	2/ ADMIN.
TOTAL SALARIES	$22,137	$14,373	$39,837	$2,400
CONTRACTUAL SERVICES	$32,236	$17,325	$8,436	$1,900
EQUIPMENT (lease or purchase)	$38,272	$7,900	$20,206	$2,600
ALL OTHER	...	$731	$11,716	...
TOTAL	$92,645	$40,329	$80,195	$6,900
AVERAGE EMPLOYMENT				
ADP DEVELOPMENT	...	105	174	...
ADP PROGRAMMING	...	290	222	...
ADP MANAGEMENT/OPERATIONS	...	20	715	...
TELECOMMUNICATIONS	...	...	158	...
TOTAL	842	415	1,269	77

1/ WITHIN DM&S THERE IS A RELATIVELY SMALL STAFF AT EACH OF THE 172 MEDICAL CENTERS SO MANY OF THE EMPLOYEES PERFORM MORE THAN ONE FUNCTION.

TOTAL DHCP COST IS $16,011,000 AND 577 FTEE.

2/ DUE TO OVERLAPPING OF FUNCTIONS IN GENERAL ADMINISTRATION FTEE HAS NOT BEEN DISTRIBUTED BY DEVELOPMENT, PROGRAMMING AND MANAGEMENT.

QUESTION: 5. Please submit an interim evaluation and costs-to-date of the three non-DHCP VAMC's (Saginaw, Big Springs, and Philadelphia Integrated Hospital Systems), preferably the Arthur Andersen interim report from September, 1985.

ANSWER: See attached interim evaluation.

FY 1984	$ 4,200,000
FY 1985	6,345,000
FY 1986	7,641,000
TOTAL	$18,186,000

ARTHUR
ANDERSEN
&CO.

Veterans
Administration

IHS EVALUATION

PRE-AUTOMATION REPORT
DETAILED ANALYSIS

(NOTE: THIS REPORT WAS TOO VOLUMINOUS TO REPRINT. THE REPORT IS ON FILE WITH THE COMMITTEE AND WILL BE AVAILABLE FOR REVIEW UPON REQUEST.)

ARTHUR
ANDERSEN
&CO.

Veterans Administration

IHS EVALUATION

PRE - AUTOMATION REPORT
EXECUTIVE SUMMARY

July 1985

QUESTION 6: How many VA FTEE are devoted to the Department of Defense CHCS/DHCP evaluations at Fitzsimons Army Hospital in Denver, and the March Air Force Base Hospital in California, and what costs, to date, has the VA incurred for these test projects?

ANSWER:

At this time, the San Francisco ISC has a ceiling of 4 FTEE to support the March Air Force Base hospital in California and the Salt Lake City ISC has a ceiling of 4 FTEE to support the Fitzsimons Army Hospital in Denver. The costs to support these two DOS sites to date are estimated at:

Pay & Benefits	$53,800
Travel	14,701
TOTAL	$68,501

GENERAL

You stated in your testimony that in the context of the fiscal year 1986 sequester order, "the Veterans' Administration in relation to other government activities has been treated fairly in the overall distribution of budgetary resources".

QUESTION:

(a) Is this also your opinion with regard to the Administration's fiscal year 1987 budget request?

(b) (i) Compared to all other agencies, how much of a net change is the Veterans' Administration's FY 1987 budget request compared to FY 1986?

(ii) Please respond in terms of real and nominal dollar amounts percentage change from FY 1986.

(iii) Please also list the percentage changes for FY 1987 for all other agencies from the FY 1986 request.

(c) By what amount and percentage difference was the Veterans' Administration FY 1987 budget request adjusted or affected in order to allow the real growth increase for the Department of Defense budget request?

(d) If the Administration's budget request for all agencies was modeled along the deficit reduction allocation formula contained in Part C - "Emergency powers to eliminate deficits in excess of maximum deficit amount" of the "Balanced Budget and Emergency Deficit Control Act of 1985", what would the Veterans' Administration budget request for FY 1987 have been?

RESPONSE:

(a) Yes, both the President and the Congress have always given veteran programs high priority and I feel that the VA 1987 budget again reflects the Administration's commitment toward continued strong support to our nation's veterans.

(b) VA Budget Authority request of $26.6 billion declined by $400 million from the 1986 level of $27.0 billion. This represents a decline of about 1.5%. In 1987 outlays would decline by about 0.7% from $26.5 billion to $26.4 billion. Part of this is due to a normal workload decline in our readjustment benefits program and no additional funding requirements for Loan Guaranty for 1987. This, plus program reform and management improvement initiatives in our Medical Care program account for the majority of the decline.

In reviewing the budget summary tables the overall Government Budget Authority is increasing some $43 billion over 1986. These estimates, however, would include uncontrollable cost-of-living increases such as Social Security. These and any other uncontrollable increases would have to be taken into consideration before any comparison could be made with other agencies.

(c) We are not aware of any adjustment to the VA 1987 budget request to accommodate the Defense increase. Discussions with OMB on the 1987 budget for VA was confined to VA programs only. There was no discussion on the Defense budget.

(d) The formula contained in Part C pertains to the sequestration portion of P.L. 99-177 and would be essentially a 50-50 split between Defense and non-defense agencies to meet deficit increases over the annual deficit reduction goals . It would not appear, however, that this formula could be used to prepare a budget or redistribute resources for 1987 since the sequestration percentages are far different from the 1987 budget request relative percentages for defense and non-defense agencies (Defense represented about 29% of the 1987 budget request). We are, therefore, not in a position to determine how 1987 funding could be developed under P.L. 99-177.

GENERAL OPERATING EXPENSES

1. The net gain of FTEE for DVB in FY 1987 appears to be a very small increase over FY 1986 primarily because most of the 400 FTEE increase is the result of transferred FTEE.

Question 1(a):	In actuality, the FY 1987 DVB FTEE level appears to be much lower than the FY 1985 level. What impact will this have on services provided by DVB?
Response:	The 1987 level is clearly below the 1985 actual level. However, with modernization and other improvements the Department will continue working to maintain existing levels of service.
Question 1(b):	Will a reprogramming request be necessary to offset any adverse impact on the FTEE level for FY 1987, and if so, what amount of additional funds and FTEE would be necessary?
Response:	At this time, a reprogramming request is not anticipated for FY 1987.

QUESTION 2:

The budget books indicate that as a result of proposed legislation, additional resources of $952,000 are requested for the Office of General Counsel for FY 1987 for the recovery or collection from health insurers for the cost of VA care provided to non-service-connected disabled veterans. The budget also indicates a reduction in FTEE during 1985 will require a shift of personnel from debt collection activities to loan guaranty foreclosure activities.

a. How many personnel in the Office of General Counsel will be allocated to debt collection activities during FY 1987?

b. How many personnel will be specifically allocated to third party collection or reimbursement activities during FY 1987 if legislation is enacted? Please include assumptions made in deriving the allocation.

c. Please comment on the adequacy of funding and personnel levels requested for FY 1987 for the personnel listed in parts (a) and (b) with respect to estimated workload.

Response:

a. 122 FTEE (6 FTEE fewer than 1986, 44 FTEE fewer than 1985).

b. The enactment of legislation requiring recovery of medical care costs from third party health insurers will require an estimated employment of 25 FTEE and $952 thousand. These estimates are based on DM&S estimates of the number of discharges subject to billing and an assumption that, initially, one-half of one percent of these billings will be contested and require litigation to settle. The number of contested cases will taper off over time as insurers begin to accept our right to bill them for services. We have assumed that the same effort (manhours) will be required per case as is currently consumed in our debt collection program.

c. Funding and personnel requested for third party reimbursement (25 FTEE and $952 thousand) will be adequate to implement this activity if our assumption that one-half of one percent of billings will be challenged. We believe this to be a good assumption.

Funding and personnel requested for debt collection (122 FTEE and $4.4 million) may not be adequate to maintain collections in excess of the $16 million we collected in 1985. In 1985 this program employed 166 FTEE. The shifting of 44 FTEE (26%) to torts, personnel work, litigation and other nondiscretionary, growth areas may lessen collections by about 20% or $3 million.

READJUSTMENT BENEFITS

Question:

The budget books indicate that beginning in FY 1987 beneficiary travel for vocational rehabilitation trainees will be funded by the readjustment benefits account. The cost of beneficiary travel in 1987 will be $750,000.

1 A) From what account was this activity previously funded and why is it being transferred this year?

RESPONSE 1.A. This travel was previously funded in the General Operating Expenses appropriation. Funding will not be transferred to Readjustment Benefits until 1987. The General Counsel opinion basically stated that since the payment of beneficiary travel was specifically mentioned in Chapter 31 as one of the services to be provided it would be proper to include the cost of the travel in the vocational rehabilitation portion of the budget request. Since this opinion was not issued until after the start of 1986, it was decided to implement this change in 1987.

Question:

B) Will there be a net increase or decrease for FY 1987 compared to FY 1986 and will the net funding level be affected as a result of the transfer?

Response:

The 1986 level is expected to be $800 thousand, or $50 thousand greater than the 1987 level. The net funding level for the agency will not change in 1987 as a result of this transfer.

Question:

C) In what line item of the readjustment benefits account are the funds for this activity included?

Response:

These funds appear under the Vocational Rehabilitation line item.

Question:

D) Will the $750,000 in FY 1987 be absorbed from the current services baseline for readjustment benefits or are additional funds being requested?

Response:

Additional funds are being requested for the Readjustment Benefits account. However, it must be pointed out that the General Operating Expenses request has been reduced by a like amount.

E) What criteria will be used to determine eligibility for the special transportation allowance and is the funding level in the request sufficient for FY 1987?

Response 1.E. Special transportation allowance may be provided during extended evaluation, rehabilitation to point of employability, independent living services and employment services. This allowance may not exceed the lesser of actual expenses or one half of the monthly subsistence allowance. This payment and the eligibility criteria are discussed in Title 38 (section 111). Funding for the special transportation allowance is included in the 1987 readjustment benefit appropriation and is considered adequate for the intended purpose.

LOAN GUARANTY

Question 1: In your budget request for fiscal year 1987, you estimate that total obligations for the Loan Guaranty Revolving Fund will be $2,576 million. You further estimate that your offsetting collections will total $2,424 million leaving you with an estimated balance of $152 million. The budget request further calls for a transfer of $125 million from the Direct Loan Revolving Fund to the Loan Guaranty Revolving Fund. If such a transfer were to take place, the estimated balance then would be $27 million. How does the VA intend to cover the $27 million still outstanding without requesting an appropriation for fiscal year 1987?

Response 1: The $27 million would be funded by an anticipated $167.4 million in unobligated funds brought forward from 1986. This is illustrated on page 2-9 of Volume I of the 1987 President's Budget (Veterans Administration).

Question 2: Your budget request anticipates that $145.4 million will be generated through the Loan Origination Fee. Is that estimate based on the existing 1% user fee or the requested increase in the user fee to 2% for fiscal year 1987, and how does that estimate relate to the projected decrease in outlays of $131.8 million?

Response: The loan origination fee estimate of $145.4 million is based upon a 1% fee. The projected savings of $131.8 million reflects both the higher fee and an anticipated 5% reduction in loan originations.

QUESTION 3: In your budget request you projected that you would close or insure 200,000 loans during fiscal year 1987; however, at this time your revised projection for fiscal year 1986 totals 270,000 loans. Based on an increase of almost 100,000 loans from your original fiscal year 1986 projection, do you feel that a projection of 200,000 loans for fiscal year 1987 is accurate? If not, what would be a more accurate estimation of the number of loans guaranteed or closed during fiscal year 1987, and what would be the budget impact of a revised estimate?

RESPONSE 3: The 1987 estimate of loan volume was formulated when the maximum VA mortgage rate was 12.5 percent. Later in the budget process mortgage interest rates decreased to 11.5 percent. VA's estimate of loan volume did not contemplate a decline to the current rate of 9.5 percent (the lowest level in seven years). If the rate remains at this level, or drops even lower, the VA should continue to experience higher than projected loan volume. The 1986 base estimate (prior to sequestration) has been increased by Congress to $18.2 billion. It is felt that the 1987 guaranteed loan volume could be even higher. However, the VA is currently reviewing this program to determine revised estimates based upon the decline in interest rates and increased program activity. The revised projection should be available shortly.

QUESTION 4: Based on your estimated loan guaranty volume for fiscal year 1987, whether it be your current number of 200,000 or a revised projection, what percentage of the loan volume do you anticipate will be in the form of refinancing? If a revised estimate of loan activity is provided, what percentage of such activity would be the result of restoration of entitlement?

RESPONSE 4: We project that refinancing will account for approximately ten percent of our volume for FY 1987. This reflects the level of refinancing expected during a period of stable interest rates. In FY 1986, however, due to rapidly declining interest rates, we project refinancing to account for 20 percent of loan volume. We also estimate that about ten percent of the FY 1987 activity will be restored entitlement loans.

QUESTION 5: The numbers included in your fiscal year 1987 budget request show a reduction in both claims processed and the number of properties acquired during fiscal year 1987. What lead you to determine that the number of claims processed and the number of properties acquired during this coming fiscal year would be lower than during fiscal year 1986?

RESPONSE 5: The Loan Guaranty Revolving Fund budget estimate for claims and property acquisitions indicates a downward trend in fiscal years 1986 and 1987. This estimate is based on the Administration's projections for steady long term economic growth and low unemployment. These conditions should contribute to a decline in foreclosures and their related costs to the revolving fund.

QUESTION 6: You currently acquire about 90% of the foreclosed loans guaranteed by the VA. Is your projected decrease in property acquisitions for FY 1987 based on a lower percentage of total foreclosures or a reduction in the number of foreclosures?

RESPONSE 6: The projected decrease in property acquisitions for FY 1987 was based upon a reduction in the number of foreclosures.

LOAN GUARANTY: AUCTIONS

QUESTION 1. A): Once the decision was made to hold a series of auctions to sell off VA-foreclosed properties, was any different policy adopted regarding the acquisition of foreclosed properties versus "paying off" the guaranty? If not, why not?

QUESTION 1. B): How many foreclosed properties in Houston has the VA bought back since the first Houston auction?

RESPONSE 1. A): VA policy concerning property acquisition decisions has not changed as a result of the use of auctions to dispose of portions of our inventory. The governing law (38 USC 1816 (c), as added by Public Law 98-369) requires VA to determine the net value of each property at the time of foreclosure and to accept conveyance when the purchase of a property for its net value would reduce the amount of guaranty payable. We have consistently followed this procedure nationwide. We would like to point out, however, that properties sold at auction are not generally representative of our inventory. Emphasis is placed on using the auction technique to dispose of hard to sell properties which have been in VA's inventory for extended periods. During that time, these properties have been exposed to the market through listings with real estate brokers. The decision to acquire the bulk of these properties was made over two years before the auction. This was well in advance of the current market problems in the Houston area.

RESPONSE 1. B): The first Houston auction was held on June 7, 1985 at which VA sold 175 houses. Between June 1, 1985 and January 31, 1986, our Houston office purchased 1,803 properties as a result of GI loan foreclosures. During the same period, the Houston office sold 1,540 properties.

QUESTION 2: How does the foreclosure rate in Houston differ from that in other areas--generally and broken down to compare Houston to other depressed housing market areas?

RESPONSE 2: During calendar year 1985 the foreclosure rate at our Houston office was 1.5 percent, which was more than twice the nationwide rate of .7 percent for that period. The Houston foreclosure rate was comparable to that of other depressed housing market areas in 1985. For example, the rate at our Des Moines, Iowa office was 1.4 percent; Seattle, Washington was 1.5 percent; Cleveland, Ohio was 1.2 percent; and Chicago, Illinois was nearly 2 percent.

QUESTION 3A: Provide for the record a complete list of all the VA properties in Houston which have been auctioned, including the original sale price, appraisal for each home at the time of sale, price when sold at auction, and appraisal at time of auction.

RESPONSE 3A: Chart showing requested data attached.

HOUSTON AUCTION
JUNE 1985

Auction Number	Property Management Number	Original Sales Price	Default Appraisal	Cash Market Value	Auction Sales Price
1	25194	***	60,040	30,000	40,000
2	478142	43,800	52,000	39,000	33,000
3	517330	60,000	83,000	52,000	51,500
4	515064	62,900	65,600	43,500	44,000
5	541744	54,000	48,000	33,000	37,500
6	521324	45,000	55,000	36,000	34,000
7	491830	49,000	53,500	31,000	23,000
8	497661	45,900	47,850	27,000	29,500
9	452009	33,500	39,000	27,000	25,500
10	21362	***	24,000	21,000	18,000
11	25978	60,000	65,900	50,000	44,000
12	496357	32,000	35,000	21,000	20,000
13	496374	54,400	56,700	30,000	26,000
14	520363	62,000	62,000	22,500	23,500
15	495156	43,000	40,400	15,000	12,000
16	515417	50,000	55,000	20,000	18,500
17	516727	50,000	51,200	20,000	17,500
18	26022	***	60,775	39,000	24,000
19	498446	53,500	54,650	36,000	28,000
20	492315	63,300	64,500	45,000	45,000
21	548785	29,900	33,950	20,000	7,500
22	517603	42,250	53,150	23,000	21,000
23	26214	***	50,525	14,000	25,000
24	26370	***	33,975	18,000	16,000
25	453653	45,000	51,750	31,000	22,000
26	26705	***	49,975	26,000	19,500
27	492663	44,150	38,200	22,000	16,000
28	568306	60,800	54,600	35,000	37,000
29	523534	74,900	82,200	53,000	57,000
30	522918	50,500	61,000	37,000	40,000
31	538957	76,950	76,950	52,000	40,000
32	482242	17,800	26,400	17,000	16,500
33	499960	56,990	57,900	41,500	41,500
34	522806	21,900	30,500	13,500	10,000
35	27444	***	45,000	24,500	24,000
36	430027	47,700	51,500	38,000	33,000
37	538213	84,900	84,900	52,000	55,500
38	26383	***	40,475	24,000	22,000
39	24950	***	28,350	17,000	17,000
40	450021	27,500	31,500	24,000	13,500
41	474843	50,000	53,300	25,000	23,500
42	427541	37,750	45,000	41,000	32,500
43	550656	50,250	48,450	21,500	26,000
44	503025	54,400	65,750	46,000	39,000

HOUSTON AUCTION
JUNE 1985

Auction Number	Property Management Number	Original Sales Price	Default Appraisal	Cash Market Value	Auction Sales Price
45	475736	52,000	49,150	46,000	25,500
46	433053	45,500	62,000	43,000	41,000
47	553943	60,950	53,450	44,000	35,500
48	389439	49,300	60,000	50,000	45,000
49	537121	50,000	53,500	30,000	23,000
50	435205	45,150	61,500	46,000	27,000
51	521197	36,500	40,150	21,300	23,000
52	515732	47,500	47,000	33,000	42,500
53	27014	***	51,975	30,000	28,500
54	460134	45,000	45,000	26,000	47,000
55	26426	***	44,000	25,000	21,500
56	494160	59,500	73,050	48,000	49,500
57	26479	***	59,975	28,000	16,500
58	493378	54,000	56,000	22,000	21,000
59	385938	42,000	62,950	45,000	38,000
60	26492	***	63,700	36,500	25,500
61	459886	65,000	85,375	55,000	56,000
62	436200	20,800	19,000	12,000	10,000
63	25393	***	41,950	25,500	28,000
64	430277	44,650	49,600	19,000	8,500
65	409315	19,000	28,000	8,000	8,000
66	521068	49,000	47,000	22,000	15,000
67	536451	50,000	57,200	35,000	33,000
68	26847	***	44,900	24,000	24,500
69	520321	54,950	67,200	29,000	41,000
70	26146	***	51,500	36,000	39,500
71	457379	42,500	42,975	40,000	39,000
72	26605	***	49,270	21,500	21,000
73	570886	39,990	46,500	33,000	25,000
74	570769	52,950	58,500	37,000	32,000
75	548718	55,950	58,000	44,000	36,500
76	428018	29,500	41,500	20,000	11,000
77	475834	38,500	43,825	30,000	30,000
78	25499	***	39,750	23,500	14,500
79	541258	70,000	74,750	50,000	47,000
80	522235	29,650	35,590	20,800	19,000
81	458639	21,450	27,500	10,000	13,500
82	434607	48,950	63,300	40,000	40,000
83	520799	61,000	61,000	40,000	38,000
84	551842	65,600	64,300	45,000	52,000
85	472323	64,500	64,500	32,000	32,000
86	497684	36,000	40,000	9,000	8,500
87	26517	***	69,700	42,000	38,500
88	400527	23,500	26,750	18,900	11,000

HOUSTON AUCTION JUNE 1985

Auction Number	Property Management Number	Original Sales Price	Default Appraisal	Cash Market Value	Auction Sales Price
89	26672	***	34,000	15,000	9,000
90	499661	48,450	51,900	22,000	24,000
91	27483	***	63,900	38,000	43,000
92	500330	41,500	60,800	15,000	20,500
93	586954	64,000	47,000	20,000	28,000
94	553107	56,000	45,000	15,000	22,000
95	521145	54,500	61,600	20,000	28,500
96	502830	48,950	48,950	22,000	32,000
97	523214	53,000	54,000	30,000	36,000
98	24882	***	45,000	15,000	27,000
99	456685	28,750	38,600	10,000	23,000
100	515925	32,000	44,800	19,000	25,000
101	26106	***	38,425	20,000	16,000
102	515463	53,300	59,000	35,000	32,500
103	524655	45,800	64,000	35,000	36,000
104	524876	54,800	57,500	35,000	34,000
105	479502	32,600	36,700	22,000	24,500
106	27478	***	29,850	15,000	10,500
107	481604	22,000	27,400	15,000	11,000
108	436740	29,500	27,775	17,000	11,000
109	541912	66,950	69,100	33,000	63,000
110	523353	26,000	27,000	10,000	16,000
111	450706	24,650	38,400	19,500	15,000
112	16456	***	14,300	10,000	15,000
113	25492	***	30,800	18,000	14,000
114	431678	44,000	53,800	32,500	39,000
115	26201	***	34,550	15,000	20,000
116	516756	29,500	35,600	10,000	10,500
117	472663	25,000	35,300	19,000	10,000
118	492210	63,450	67,750	54,000	60,000
119	23587	***	41,800	35,000	23,000
120	542842	46,500	46,500	22,000	28,000
121	540054	37,000	40,200	26,000	25,000
122	495215	50,000	56,000	22,500	29,000
123	587177	60,000	65,600	37,000	39,500
124	543382	44,950	44,950	15,000	20,000
125	514404	38,500	47,000	15,000	18,000
126	500675	49,000	54,000	34,500	40,000
127	472409	42,000	67,500	20,000	30,000
128	26065	***	50,275	24,000	40,000
129	495382	24,500	29,100	10,000	13,500
130	27582	***	68,100	41,500	35,500
131	521180	67,000	75,500	46,500	46,000
132	537453	54,000	58,900	36,000	26,000

HOUSTON AUCTION
JUNE 1985

Auction Number	Property Management Number	Original Sales Price	Default Appraisal	Cash Market Value	Auction Sales Price
133	477071	51,500	52,050	40,000	42,500
134	567362	42,500	43,100	21,000	19,000
135	26197	***	54,975	33,000	39,000
136	477495	57,500	61,260	45,750	45,000
137	481091	61,500	70,000	47,750	44,500
138	25583	***	49,650	25,000	28,000
139	499911	25,000	30,550	10,300	9,000
140	519504	32,600	41,900	16,150	19,000
141	454102	60,000	64,450	42,500	46,500
142	26256	***	56,500	32,000	33,000
143	472340	35,000	40,250	18,000	20,500
144	406167	22,700	20,400	6,000	7,000
145	26499	***	51,475	25,000	22,000
146	523081	57,500	57,700	27,000	38,000
147	430156	31,500	47,300	24,000	25,000
148	26404	***	36,025	25,000	18,500
149	517965	29,600	28,100	12,000	22,500
150	26881	***	78,650	53,000	58,500
151	520048	47,000	50,750	30,000	27,000
152	27446	***	43,500	30,000	28,000
153	26638	***	52,975	28,000	32,000
154	493576	50,000	51,800	30,000	42,500
155	524317	50,500	49,800	36,500	47,000
156	26085	***	39,975	25,000	18,500
157	26510	52,975	52,975	10,000	17,000
158	407231	33,700	49,400	25,000	31,000
159	470969	20,300	33,000	10,000	14,000
160	524426	32,500	40,850	20,000	19,500
161	494719	48,950	58,750	35,000	34,000
162	565111	64,500	59,000	30,000	40,000
163	20151	***	35,000	24,000	28,000
164	536904	62,000	70,000	40,000	45,000
165	480957	39,950	53,100	33,000	27,000
166	26908	***	61,950	27,000	37,000
167	539713	64,000	64,000	22,500	35,000
168	544589	44,450	44,450	15,000	22,000
169	540206	50,000	45,700	17,500	23,500
170	550605	61,500	56,000	22,500	34,000
171	496080	45,965	59,500	25,000	20,000
172	493273	30,950	40,250	12,000	20,500
173	26575	***	46,000	24,000	28,000
174	554334	53,000	53,000	22,500	34,000
175	537712	61,300	62,000	30,000	49,000

*** Vendee loans - No CRV's

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
1	20970	NA	15,500	NA	10,710	3,500
2	26228	NA	35,000	NA	11,475	6,000
3	425985	24,500	26,825	14,700	13,770	5,500
4	517626	32,500	25,000	19,500	13,000	10,500
5	525160	32,700	33,000	19,620	21,100	6,500
6	514467	50,000	27,000	27,500	22,600	7,000
7	574060	29,900	29,900	17,940	16,800	7,750
8	454224	29,800	35,950	17,880	14,500	6,000
9	537747	44,300	44,000	26,580	18,360	8,250
10	543623	35,000	39,500	21,000	14,500	8,250
11	501317	26,000	28,400	14,000	15,300	6,500
12	494876	47,000	39,500	27,500	16,800	12,000
13	24106	NA	43,400	NA	15,300	5,000
14	544471	27,300	29,000	16,380	15,300	3,250
15	453183	46,450	50,000	25,000	18,000	19,500
16	552357	62,300	59,500	27,500	21,800	17,000
17	495580	37,500	39,550	22,500	29,000	9,000
18	525343	36,800	41,450	23,160	10,300	4,000
19	492580	54,900	39,000	25,000	19,100	20,000
20	537951	36,500	40,000	21,900	26,000	6,500
21	477803	33,000	35,600	19,150	22,950	16,750
22	525598	54,450	54,750	27,500	27,500	17,000
23	568533	47,000	39,900	27,500	29,500	15,000
24	538087	42,500	42,250	25,500	32,100	20,000
25	537907	36,500	37,200	21,900	34,800	15,000
26	524829	43,500	52,500	26,100	25,250	16,000
27	502438	34,000	43,000	20,400	15,300	12,750
28	539256	61,950	55,000	27,500	28,700	24,250
29	514705	41,500	36,000	12,800	33,300	26,000
30	501607	39,900	48,000	23,940	24,500	13,500
31	539737	45,500	48,200	26,320	25,250	13,000
32	540232	48,250	57,400	12,200	24,500	10,500
33	433748	35,500	46,700	21,300	27,500	12,000
34	542209	45,000	44,000	26,970	20,700	15,000
35	523047	46,600	46,600	27,500	26,400	26,000
36	549303	50,950	50,950	27,500	24,900	13,500
37	524030	44,950	47,550	26,920	23,700	22,750
38	502708	47,700	48,600	27,500	39,400	25,000
39	543425	50,700	59,850	27,500	25,600	19,750
40	519473	50,000	52,700	27,500	30,600	25,000
41	544873	53,950	62,850	27,500	22,200	26,500
42	25973	NA	63,100	NA	23,000	19,500
43	551567	65,750	58,250	27,500	30,600	28,250
44	26453	NA	57,500	NA	38,250	21,750
45	524793	49,950	55,000	27,500	38,250	32,500
46	536903	42,000	50,000	25,500	29,800	17,000
47	480299	49,250	64,900	25,000	38,250	21,500
48	501638	51,000	66,500	12,750	9,950	25,000
49	538491	53,000	55,000	27,500	29,500	28,500
50	493837	68,600	57,250	24,633	45,500	28,500
51	389439	49,300	60,000	11,575	45,900	17,500
52	26280	NA	70,000	NA	47,400	32,000
53	477805	65,000	71,500	16,000	15,300	15,000
54	516821	62,500	60,000	27,500	48,600	16,000

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
55	433234	45,000	69,700	17,500	51,600	31,000
56	522710	60,500	74,800	27,500	38,250	32,500
57	517330	60,000	83,000	27,500	39,800	40,500
58	405912	48,000	59,950	17,500	55,900	33,000
59	519106	66,900	71,800	16,730	39,000	25,000
60	501629	76,500	82,000	27,500	61,100	49,000
61	449797	66,500	69,000	25,000	48,200	42,500
62	492604	74,500	73,000	25,000	40,500	45,000
63	524506	140,000	142,000	10,000	75,700	87,000
64	498262	75,200	78,000	25,000	42,850	47,000
65	540906	83,950	89,000	27,500	43,200	57,000
66	569378	80,850	71,000	27,500	42,100	41,000
67	522021	64,950	55,000	27,500	59,300	40,000
68	518834	63,000	77,800	27,500	52,000	32,500
69	522126	69,900	74,300	27,500	38,600	49,000
70	522071	70,700	76,500	27,500	39,400	40,000
71	501412	62,950	68,000	27,500	33,650	40,000
72	515987	60,900	69,500	27,500	49,300	35,000
73	472443	57,000	58,700	25,000	39,000	38,000
74	566043	61,950	61,950	18,124	34,100	32,000
75	524583	57,950	65,600	27,500	42,100	28,000
76	583095	56,950	62,300	27,127	34,100	33,000
77	516697	60,000	70,000	15,000	37,500	44,500
78	549289	59,500	60,000	27,500	44,800	28,000
79	413080	48,200	60,000	17,220	35,600	36,000
80	566636	56,500	56,500	27,500	40,163	21,750
81	540649	56,500	56,350	27,500	34,050	25,000
82	553530	62,000	58,000	27,500	32,512	27,500
83	520569	57,950	59,000	27,500	30,600	27,500
84	538693	59,450	61,600	27,500	41,300	37,000
85	574691	58,000	52,000	27,500	37,900	27,500
86	26416	NA	57,200	NA	32,500	15,500
87	540818	47,950	48,300	27,500	37,500	24,000
88	472837	38,000	47,100	22,800	30,600	27,000
89	538793	47,450	55,000	27,500	35,200	16,000
90	545489	51,950	60,500	27,500	27,500	28,000
91	539714	53,450	64,675	16,035	25,600	21,500
92	26850	NA	61,200	NA	27,500	19,000
93	521560	44,950	46,500	26,970	37,100	21,500
94	540248	48,150	49,000	27,500	22,600	22,500
95	433067	36,800	43,900	26,599	24,500	21,000
96	501983	46,500	46,800	27,500	25,250	24,500
97	519225	44,500	51,000	25,770	19,100	20,000
98	492962	39,300	46,900	23,580	27,500	15,250
99	537275	39,500	39,800	23,700	19,500	7,250
100	549802	48,200	43,750	27,500	27,500	21,000
101	542581	48,500	51,500	27,500	32,100	16,000
102	571494	47,700	39,000	27,500	24,500	7,000
103	481699	43,000	39,000	23,970	20,700	12,250
104	493399	48,950	63,400	25,000	29,100	26,750
105	26119	NA	35,000	NA	20,700	5,250
106	543456	33,500	35,300	20,100	20,700	7,000
107	524067	62,500	50,500	27,500	28,700	19,500
108	26472	NA	33,500	NA	19,100	12,000

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
109	524764	35,000	38,500	16,800	25,600	18,500
110	481041	49,950	54,000	25,000	18,000	21,250
111	517565	56,500	49,000	27,500	24,900	17,000
112	26312	NA	35,500	NA	29,100	10,000
113	540920	25,000	33,500	15,000	19,125	6,500
114	545048	32,000	30,900	18,930	11,500	7,000
115	523883	34,900	35,800	20,940	19,100	4,250
116	539956	37,950	40,000	22,770	23,000	11,500
117	545810	29,900	26,600	14,590	7,650	5,500
118	517976	22,500	31,150	13,500	17,200	9,500
119	23987	NA	17,000	NA	4,590	4,750
120	554599	40,000	35,000	16,600	14,200	15,500
121	26103	NA	33,000	NA	16,800	22,000
122	16456	NA	14,300	NA	9,600	5,000
123	501701	47,500	32,500	27,500	16,100	12,500
124	14223	NA	8,000	NA	5,350	4,250
125	459748	31,800	30,000	11,400	1,150	3,000
126	25523	NA	27,000	NA	9,950	9,000
127	497684	36,000	40,000	21,600	6,100	3,000
128	387102	10,500	25,000	6,300	11,500	6,000
129	28137	NA	29,500	NA	25,250	12,000
130	515435	50,000	49,000	27,500	19,900	9,500
131	26177	NA	25,550	NA	13,000	6,500
132	25613	NA	39,500	NA	19,900	7,500
133	24024	NA	20,100	NA	8,000	6,500
134	406191	13,500	24,900	8,100	12,250	8,000
135	25207	NA	32,500	NA	13,000	3,000
136	539698	44,500	45,500	26,670	23,700	15,000
137	25334	NA	32,550	NA	24,900	9,500
138	519514	29,900	39,600	10,000	15,700	11,000
139	536639	43,900	43,400	25,740	15,300	14,000
140	481094	57,500	45,000	25,000	18,700	27,000
141	389148	30,550	15,000	8,576	19,100	7,000
142	546386	36,700	35,500	21,900	21,420	12,500
143	537912	35,500	41,000	21,300	19,100	15,000
144	550607	61,500	56,000	27,500	27,500	23,000
145	522456	35,000	42,500	11,300	22,500	21,000
146	435744	34,500	40,200	20,700	19,100	16,000
147	542570	46,000	51,350	27,500	29,500	17,000
148	492676	38,500	47,000	23,100	18,700	19,000
149	26053	NA	65,000	NA	27,500	35,000
150	542842	46,500	46,500	27,500	21,400	20,000
151	546298	49,250	51,100	22,500	24,900	22,500
152	536667	43,000	43,000	27,500	25,250	17,000
153	540652	45,500	48,500	26,970	25,600	17,000
154	570354	54,000	54,000	27,500	23,700	23,000
155	524861	39,300	46,500	23,580	23,300	19,000
156	544034	60,000	57,000	27,500	25,600	23,000
157	518468	62,500	64,150	27,500	32,900	35,000
158	540269	45,500	46,450	26,970	22,950	17,000
159	519972	51,950	51,950	27,500	34,000	24,000
160	537137	54,800	52,500	27,500	32,500	20,000
161	26502	NA	52,000	NA	29,800	21,000
162	449264	42,100	57,500	25,260	29,800	21,000

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
163	27358	NA	53,250	NA	39,000	18,000
164	554125	54,800	52,400	27,500	22,950	17,500
165	548472	48,500	52,000	23,000	32,100	17,500
166	476784	49,950	60,200	24,189	30,600	33,000
167	544684	50,150	54,500	27,500	28,700	32,000
168	501200	53,850	60,000	20,000	30,600	30,000
169	499240	50,500	61,600	17,500	27,500	34,000
170	545740	63,000	58,000	27,500	27,500	22,000
171	525769	62,000	62,000	27,500	30,200	22,000
172	519595	55,450	64,000	27,500	35,200	40,000
173	456285	52,950	62,250	25,000	34,400	32,000
174	548226	63,000	65,000	27,500	38,250	34,000
175	550723	58,500	62,850	22,500	29,800	26,000
176	27270	NA	71,800	NA	34,400	42,000
177	470906	49,425	63,000	25,000	44,800	38,000
178	523563	60,000	74,700	27,500	48,200	29,000
179	545792	64,000	65,000	27,500	34,400	41,000
180	517147	67,200	67,700	27,500	47,800	40,000
181	25424	NA	73,500	NA	53,200	33,000
182	495733	59,000	72,000	15,025	38,250	40,000
183	494103	66,550	66,550	25,000	47,000	40,000
184	524256	64,950	77,250	27,500	34,800	38,000
185	474175	68,950	78,500	25,000	62,000	55,000
186	495929	64,000	69,000	25,000	39,800	43,000
187	516244	76,450	80,000	22,500	59,300	58,000
188	479064	88,500	105,050	25,000	53,500	70,000
190	520621	73,000	76,450	27,500	37,500	46,000
191	540410	77,850	82,500	27,500	46,300	46,000
192	547369	75,650	71,000	30,000	39,000	56,000
193	521001	65,950	66,950	27,500	36,300	40,000
194	455932	53,000	68,250	17,467	45,900	37,000
195	25893	NA	60,250	NA	52,000	40,000
196	540227	61,450	66,000	27,500	42,100	41,000
197	570037	68,900	69,000	27,500	34,400	35,000
198	541358	61,250	67,350	27,500	42,075	45,000
199	25978	NA	65,900	NA	25,250	35,000
200	501033	55,500	64,200	27,500	28,300	37,000
201	537674	59,450	59,000	27,500	35,600	37,000
202	522524	58,000	60,450	15,000	37,500	41,000
203	516307	60,500	65,650	27,500	31,800	38,000
204	430629	52,500	54,500	25,000	34,400	42,000
205	542224	54,000	54,000	27,500	34,800	33,000
206	26525	NA	62,000	NA	29,100	27,000
207	547818	58,500	60,500	27,500	30,600	25,000
208	572856	65,000	63,000	27,500	28,300	36,000
209	524986	58,500	56,900	27,500	30,600	32,000
210	27397	NA	54,800	NA	33,700	28,000
211	471242	39,000	50,400	23,400	28,300	28,000
212	524855	46,600	49,000	27,500	26,000	36,000
213	541371	51,950	53,000	27,500	22,200	26,000
214	549065	50,500	53,450	20,900	26,800	30,000
215	545945	51,750	52,000	27,500	30,600	26,000
216	537159	45,500	51,085	26,370	21,800	20,000
217	26781	NA	60,950	NA	35,600	32,000

Houston Auction February, 1986

Auction #	Pm #	CRV	F/C APPR	MAX GTY	CASH M/V	SALE PRICE
218	545835	52,000	54,000	27,500	30,600	28,000
219	550656	50,250	48,450	27,500	35,600	20,000
220	455367	42,500	48,100	25,000	35,950	27,000
221	625588	41,000	39,600	22,800	30,600	22,000
222	525309	39,900	41,200	23,940	22,950	22,000
223	540462	46,500	46,600	27,500	35,950	23,000
224	543817	42,500	47,000	25,500	22,950	13,000
225	548320	42,000	42,200	25,200	26,400	12,500
226	475315	30,000	41,000	18,000	30,600	16,000
227	449390	31,500	40,500	18,900	22,200	14,000
228	503053	45,950	46,000	27,500	27,900	21,000
229	26211	NA	47,000	NA	11,500	24,000
230	475914	30,000	39,800	7,500	20,700	14,000
231	25289	NA	36,000	NA	21,800	10,000
232	502140	43,400	45,000	26,040	18,000	25,000
233	496087	33,000	38,000	19,800	17,200	16,000
234	399987	35,500	20,000	11,970	19,000	12,000
235	498439	52,000	47,000	24,870	21,000	17,000
236	521398	37,000	36,500	22,200	20,600	18,000
237	543381	44,950	41,000	26,970	13,400	17,000
238	521833	31,875	31,750	17,880	19,100	13,000
239	492958	36,950	33,000	19,950	14,900	18,000
240	539573	23,600	23,600	14,160	11,500	7,000
241	26789	NA	21,000	NA	12,600	6,000
242	524141	31,500	33,800	18,900	15,300	9,000
243	553450	31,750	38,200	19,050	15,300	8,500
244	480863	31,600	29,150	18,960	14,500	7,500
245	497910	49,000	35,000	25,000	13,800	18,000
246	411917	25,000	35,500	15,000	13,800	13,000
247	514437	47,500	30,000	27,500	12,600	16,000
248	25858	NA	24,400	NA	10,700	16,000
249	410238	18,500	14,000	11,100	4,200	4,000
250	26443	NA	8,200	NA	1,912	4,000

Values for CRV and maximum guaranty are not available (NA) for vendee loan foreclosures.

QUESTION 3B: Provide a breakdown of purchasers at these auctions by veteran/non-veteran, single buyer, corporate or group buyer, and note if any purchasers were VA employees.

RESPONSE 3B: Since all properties were sold for cash, buyers were not required to identify themselves as veterans or nonveterans. Employees of the regional office were not permitted to purchase properties at the auction.

	June 1985	February 1986
Buyers of one property	126	181
Buyers of two or more properties	22	23
Total Number Properties Sold	175	249

QUESTION 4: How much did each Houston auction cost? Provide a total figure as well as a breakdown of all specific costs. Include the cost of the auctioneer, and whether he has received a fee or a percentage of the total sales.

RESPONSE 4: Under the terms of the competitively-awarded auction contract, the auctioneer receives reimbursement for advertising expenses, not to exceed $50,000 per auction assignment, plus 7% of the sales price obtained at auction. For the Houston auctions, the auctioneer was authorized the maximum $50,000 advertising budget. Advertising budgets are reviewed and approved in advance by VA. This fee covers such items as: radio, TV and newspaper advertising, printing and mailing auction brochures, printing of sale booklet listing the properties to be sold, and the printing and posting of signs on each property to be auctioned.

The auctioneer's commission on each Houston auction was based on the following total sales prices:

June 1985 Auction		February 1986 Auction	
Total sales price	- $4,982,000	Total sales price	- $5,640,750
Commission	- $ 348,740	Commission	$ 394,852

QUESTION 5A. Were all homes "on the block" to be sold regardless of the price they brought or were there specific guidelines such as a reasonable selling price?

QUESTION 5B. Who determined the policy followed in question 5A?

RESPONSE 5A. The properties to be sold at auction were those which had been in inventory for the longest periods of time and which had not sold using the customary brokered-sale method. VA's policy was to sell these older properties at auction for the best cash price then obtainable, provided that auction attendance was sufficiently great to give some assurance that market prices would be obtainable. We were willing to let the market determine the reasonableness of the prices, so long as a substantial number of persons attended the auction. The decision to go "absolute" -- to announce that VA would accept the highest bid for each property -- was made on the scene, just prior to beginning the auction. The decision whether to go "absolute" was made by the Regional Office Director, in consultation with his own Loan Guaranty staff, a representative from the Loan Guaranty Service in Washington, and the auctioneer. 1700 persons attended each auction session on June 7 and 8, 1985. In 1986, 1,000 persons attended the February 8 auction, and 1,500 attended the February 9 auction.

RESPONSE 5B. The policy of permitting an "absolute" auction, provided that the auction was well-attended, was established by the Director, Loan Guaranty Service.

QUESTION 6. Provide for the record a copy of each contract between the VA and the auctioneer or company used for each Houston auction.

RESPONSE 6. VA has a single, nationwide contract for auctioneer services with Larry Latham Auctioneers, Inc. The contract was competitively awarded in March 1985. A copy of the contract and copies of the assignment letters to the auctioneer for both Houston auctions are attached.

SOLICITATION, OFFER AND AWARD

1 CERTIFIED FOR NATIONAL DEFENSE UNDER BDSA REG 2 AND/OR DMS REG 1 ▶ RATING

PAGE OF 1 | 54 PAGES

2 CONTRACT NO.

3 SOLICITATION NO. 26/101/1

4 TYPE OF SOLICITATION ☐ ADVERTISED (IFB) ☒ NEGOTIATED (RFP)

5 DATE ISSUED 1/24/85

6 REQUISITION/PURCHASE NO. N/A

7 ISSUED BY CODE

Veterans Adminstration(26)
810 Vermont Ave., N.W.
Washington, D.C. 20420

8 ADDRESS OFFER TO *(If other than Item 7)*

FEB 25 1985

NOTE In advertised solicitations "offer" and "offeror" mean "bid" and "bidder".

SOLICITATION

9 Sealed offers in original and 2 copies for furnishing the supplies or services in the Schedule will be received at the place specified in Item 8, or if handcarried, in the depository listed in issuing office until COB *(Hour)* local time 2/25/85 *(Date)*

CAUTION – LATE Submissions, Modifications, and Withdrawals See Section I, Provision No. 52.214-7 or 52.215-10 All offers are subject to all terms and conditions contained in this solicitation

10 FOR INFORMATION CALL ▶ A. NAME Joe White

B. TELEPHONE NO. *(Include area code)* *(NO COLLECT CALLS)* 202-389-3214

11. TABLE OF CONTENTS

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	B	SUPPLIES OR SERVICES AND PRICES/COSTS	1			PART III – LIST OF DOCUMENTS, EXHIBITS AND OTHER ATTACH	
	C	DESCRIPTION/SPECS /WORK STATEMENT	7		J	LIST OF ATTACHMENTS	
	D	PACKAGING AND MARKING				PART IV – REPRESENTATIONS AND INSTRUCTIONS	
	E	INSPECTION AND ACCEPTANCE	2		K	REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS	13
	F	DELIVERIES OR PERFORMANCE	3				
	G	CONTRACT ADMINISTRATION DATA	7		L	INSTRS., CONDS., AND NOTICES TO OFFER	4
	H	SPECIAL CONTRACT REQUIREMENTS	[illegible]		M	EVALUATION FACTORS FOR AWARD	3

OFFER *(Must be fully completed by offeror)*

NOTE Item 12 does not apply if the solicitation includes the provisions at 52.214-16, Minimum Bid Acceptance Period

12 In compliance with the above, the undersigned agrees, if this offer is accepted within ______ calendar days (60 calendar days unless a different period is inserted by the offeror) from the date for receipt of offers specified above, to furnish any or all items upon which prices are offered at the price set opposite each item, delivered at the designated point(s), within the time specified in the schedule

13 DISCOUNT FOR PROMPT PAYMENT *(See Section I, Clause No. 52.232-8)* ▶	10 CALENDAR DAYS	20 CALENDAR DAYS	30 CALENDAR DAYS	CALENDAR DAYS
	%	%	%	%

14 ACKNOWLEDGMENT OF AMENDMENTS *(The offeror acknowledges receipt of amendments to the SOLICITATION for offerors and related documents numbered and dated)*	AMENDMENT NO	DATE	AMENDMENT NO	DATE
	#1	2-6-85		
	#2	2-20-85		

15A. NAME AND ADDRESS OF OFFEROR CODE FACILITY

Larry Latham Auctioneers, Inc.
P.O. Box 201
Moulton, Alabama 35650

16 NAME AND TITLE OF PERSON AUTHORIZED TO SIGN OFFER *(Type or print)*

Larry W. Latham
Chief Executive Officer
Larry Latham Auctioneers, Inc.

15B TELEPHONE NO *(Include area code)* 1-(800)552-9426

15C CHECK IF REMITTANCE ADDRESS IS DIFFERENT FROM ABOVE - ENTER SUCH ADDRESS IN SCHEDULE ☐

17 SIGNATURE Larry W. Latham

18 OFFER DATE 2-25-85

AWARD *(To be completed by Government)*

19 ACCEPTED AS TO ITEMS NUMBERED "A"

20 AMOUNT As applicable

21 ACCOUNTING AND APPROPRIATION 36X4025

22 SUBMIT INVOICES TO ADDRESS SHOWN IN *(4 copies unless otherwise specified)* ▶ ITEM See Item 25

23 NEGOTIATED PURSUANT TO ☐ 10 U.S.C. 2304(a)( ) ☒ 41 U.S.C. 252(c)( )

24 ADMINISTERED BY *(If other than Item 7)* CODE

25 PAYMENT WILL BE MADE BY CODE

Per each letter of assignment

26 NAME OF CONTRACTING OFFICER *(Type or print)* Robert M. O'Toole

27 UNITED STATES OF AMERICA Robert M. O'Toole *(Signature of Contracting Officer)*

28 AWARD DATE MAR 01 1985

IMPORTANT – Award will be made on this Form, or on Standard Form 26, or by other authorized official written notice

NSN 7540-01-152-8064
PREVIOUS EDITION NOT USABLE

33-132 GPO 1984 O—433-14

STANDARD FORM 33 (REV. 10-83)
Prescribed by GSA
FAR (48 CFR) 53.214(c)

PART 1

SECTION A - SOLICITATION/CONTRACT FORM

NOTICE TO OFFERORS

Attached is the offer package that you requested. Submit your proposal to supply Auctioneering Services to VA for the calendar year 1985 for the sale of single family properties (1-4 units) at authorized locations in the continental United States upon 75 days notice from VA.

If you are interested in submitting a proposal, please submit your proposal to be received by the contracting officer no later than the close of business February 25, 1985.

The required contents of the proposal are stated in the documents.

An acceptable offer submission will consist of two(2) copies of the bid documents (including fee schedule) and six(6) copies of the offeror's proposal. No portions of the submitted documents will be returned to the offeror, therefore, only expendable items or photocopies should be included in the submission.

There will not be a prebid conference.

The contract will be awarded only after a complete evaluation by a Review Panel.

"A"

Larry Latham

SECTION B - SERVICES AND COSTS

FEB 26 1985

We agree to conduct these auctions according to the specifications and conditions contained herein for the following fees:

Single Family property (Individual): 7 % of the sales price
Single Family bulk packages (two or more) 5 % of the sales price

SECTION C - SPECIFICATIONS/WORK STATEMENT

Scope

The scope of this contract will include all services necessary to conduct auctions of single family properties (1-4 units) owned by VA within the continental United States for calendar year 1985. These services will include, but are not limited to: all publicity, advertising and other promotional needs prior to each auction that are required to generate maximum public interest in the sale; the opening of an office in each auction area not less than thirty (30) days prior to the auction date to promote the auction; providing all personnel at each auction site to prepare the sales agreements and accept earnest money deposits; providing a sales closing agent to close all sales; and providing adequate security during each auction. VA will notify the auctioneer/contractor by letter when and where an auction will be conducted and the estimated number of properties to be sold at least 75 days prior to the date of the auction. In addition, sixty(60) days prior to the auction date, VA will provide the auctioneer/contractor a list of the properties to be included, the amount of earnest money deposits required on each property and the extent to which financing may be provided.

Statement of Work

The Contractor will prepare, print and distribute all necessary promotional material, maintain an on-site media specialist to generate region-wide publicity, make personal contacts to provide information to, and generate interest from, prospective qualified purchasers of VA-owned properties. All promotional material, including printed and spoken, must have prior approval of the VA contracting officer's designee whose name will be furnished to the contractor in the LETTER OF ASSIGNMENT. Live or taped media interviews will be restricted to VA personnel and a VA approved spokesperson from the auctioneer/contractor.

Signs (24" X 36") will be placed on all properties being auctioned at least 15 days prior to the auction if permitted by Federal, State and Local laws. The signs will contain only the VA's name and the name of the auctioneer/contractor, an auction number and the address and telephone number of the auction office in the area where the auction is being conducted.

VA will reimburse, dollar for dollar (actual cost only), all approved advertising and promotional expenses not to exceed $50,000 for any single auction under this contract. The expenses covered are limited to the following categories; radio and TV advertising (including production cost), newspaper advertising, the printing and mailing of brochures advertising the auction, the printing of the sales booklet listing the properties for sale and the printing and posting of signs on each property being sold. The successful auctioneer/contractor will submit a marketing plan and budget for approval to the Contracting Offices' Technical Representative within 15 days after the auctioneer/contractor is notified of an auction location by the

Contracting Officer. The auctioneer/contractor is cautioned that VA will only reimburse actual cost up to the approved amount in each category of the approved budget.

The contractor will collect earnest money deposits from and issue receipts to the successful bidders. The contractor must secure at least one backup bidder on each property. Earnest money deposits must be in the form of cashier's checks, certified checks or irrevocable letters of credit in favor of the Veterans Administration drawn on an approved lending institution or any combination of the above.

The amount of the earnest money deposits required on each property will be at the sole discretion of VA.

The contractor will select the site for the auction, subject to VA's approval, make all necessary arrangements for and conduct the auction for the sale of VA properties. It is currently anticipated (but not guaranteed) that each separate auction during this contract will have at least 75 but not more than 200 properties for sale.

The contractor will provide a sufficient number of competent personnel to prepare sales agreements and accept earnest money deposits in accordance with Federal, State and Local laws.

The contractor will, before 12 noon each day following a sale day, submit to the contracting officer's designee a computerized list showing each property sold, sales price, the buyer's name(s), address and phone number, amount of earnest money deposit, the name and address of backup offerors and a receipted deposit slip from the VA designated depository for the earnest money deposits.

The contractor will furnish VA a video tape of the entire auction plus a tape showing interviews with successful bidders, TV coverage and other related subjects that the contractor feels pertinent to the success of the auction. This second tape should not exceed 30 minutes.

In the event that an acceptable price cannot be obtained on any given property at the auction, the contractor will be allowed five business days to afford a responsible bidder an opportunity to raise his/her bid to an acceptable amount established by VA. It shall be expressly understood, however, that VA retains the full right of acceptance or rejection of any or all offers and that the contractor will not have any authority of any kind to obligate or commit the U.S. Government or VA in any way whatever.

The contractor, at his/her discretion, may or may not, cooperate with real estate brokers. Notice is given, however, that only one fee will be paid by VA and that fee will be paid to the auctioneer/contractor only. That fee will be the only amount specified in the contract. VA will not pay any minimum fee per property sold. The contractor is cautioned, however, that no arrangements that restrict or limit competition are acceptable.

VA will provide the auctioneer/contractor a deed on each property sold. However it is the responsibility of the auctioneer/contractor to close all sales at no additional cost to VA.

OFFER AND AWARD

The offeror's proposal will address the following items:

(1) The offeror's experience in conducting real estate auctions similar in type and volume to the type and volume of properties estimated to be included in these auctions throughout the United States.

(2) The offeror's staff that will be available and their areas of expertise in the field of marketing, promotions and sales.

(3) The type and extent of promotional advertising and publicity which the offeror would propose to attract the greatest number of potential buyers.

(4) The offeror's fee schedule which will include all cost for administration, management, labor, travel, etc., to conduct these auctions.

(5) Any recommendations that the offeror may wish to submit that will increase the effectiveness of these auctions and increase the net return to the VA.

As a fundamental part of the proposal, the offeror shall include a proposal for marketing the following typical VA properties:

a. City of Ft. Wayne, Indiana

A typical VA-property in Ft. Wayne is a 50 year old two story frame with 3 bedrooms, 1 bath, basement (unfinished), 1 car detached garage, 1400 sq ft. of finished space. Gas forced air heat, currently listed for $18,000.

b - City of Houston, Texas

A typical VA-property in Houston is a 4 year old brick veneer ranch build on a slab in a sub-division with 3 bedrooms, 2 baths, 2 car garage, approximately 1395 sq. ft. of heated space, build in range, oven, dishwasher, garbage disposal, central heat and air condition and fireplace. Currently listed for $65,000.

The offeror will submit a marketing plan for each of these VA properties. No representation is made by VA that properties in these locations will be made available for sale under this auction contract. The proposal may be in narrative or outline form but should be in sufficient detail to provide a complete picture of the plan. No artwork or sketches are to be submitted, but previous brochures, flyers, etc. from past experience may be submitted if desired.

Failure to submit a complete package, including the bid bond, may be cause for rejection of any offer as nonresponsive. Proposals will be submitted in six copies.

Award will be made to that responsible and responsive offeror whose offer is determined to be the most advantageous to the government in terms of price and other factors.

Bid guaranty is required in an amount not less than $20,000 (twenty thousand dollars). Failure to furnish the required bid guaranty in the proper form and amount with the offeror's proposal will require rejection of the bid in all cases except those listed in FAR 28.101-4 and may be cause for rejection even then.

The bidder to whom the award is made will be required to provide a Performance Bond, Standard Form 25, in the penal sum of $100,000 (one hundred thousand dollars) within 10 days after acceptance of any auction assignment under the contract.

SECTION E - INSPECTION AND ACCEPTANCE

52.246-4 INSPECTION OF SERVICES--FIXED-PRICE. (APR 1984)

(a) Definitions. "Services," as used in this clause, includes services performed, workmanship, and material furnished or utilized in the performance of services.

(b) The Contractor shall provide and maintain an inspection system acceptable to the Government covering the services under this contract. Complete records of all inspection work performed by the Contractor shall be maintained and made available to the Government during contract performance and for as long afterwards as the contract requires.

(c) The Government has the right to inspect and test all services called for by the contract, to the extent practicable, at all times and places during the term of the contract. The Government shall perform inspections and tests in a manner that will not unduly delay the work.

(d) If any of the services do not conform with contract requirements, the Government may require the Contractor to perform the services again in conformity with contract requirements, at no increase in contract amount. When the defects in services cannot be corrected by reperformance, the Government may (1) require the Contractor to take necessary action to ensure that future performance conforms to contract requirements and (2) reduce the contract price to reflect the reduced value of the services performed.

(e) If the Contractor fails to promptly perform the services again or to take the necessary action to ensure future performance in conformity with contract requirements, the Government may (1) by contract or otherwise, perform the services and charge to the Contractor any cost incurred by the Government that is directly related to the performance of such service or (2) terminate the contract for default.

(End of Clause)

SECTION F - DELIVERIES OR PERFORMANCE

52.212-13 STOP-WORK ORDER. (APR 1984)

(a) The Contracting Officer may, at any time, by written order to the Contractor, require the Contractor to stop all, or any part, of the work called for by this contract for a period of 90 days after the order is delivered to the Contractor, and for any further period to which the parties may agree. The order shall be specifically identified as a stop-work order issued under this clause. Upon receipt of the order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the order during the period of work stoppage. Within a period of 90 days after a stop-work order is delivered to the Contractor, or within any extension of that period to which the parties shall have agreed, the Contracting Officer shall either--

(1) Cancel the stop-work order; or

(2) Terminate the work covered by the order as provided in the Default, or the Termination for Convenience of the Government, clause of this contract.

(b) If a stop-work order issued under this clause is canceled or the period of the order or any extension thereof expires, the Contractor shall resume work. The Contracting Officer shall make an equitable adjustment in the delivery schedule or contract price, or both, and the contract shall be modified, in writing, accordingly, if--

(1) The stop-work order results in an increase in the time required for, or in the Contractor's cost properly allocable to, the performance of any part of this contract; and

(2) The Contractor asserts a claim for the adjustment within 30 days after the end of the period of work stoppage; provided, that, if the Contracting Officer decides the facts justify the action, the Contracting Officer may receive and act upon the claim asserted at any time before final payment under this contract.

(c) If a stop-work order is not canceled and the work covered by the order is terminated for the convenience of the Government, the Contracting Officer shall allow reasonable costs resulting from the stop-work order in arriving at the termination settlement.

(d) If a stop-work order is not canceled and the work covered by the order is terminated for default, the Contracting Officer shall allow, by equitable adjustment or otherwise, reasonable costs resulting from the stop-work order.

(End of clause)

52.232-19 AVAILABILITY OF FUNDS FOR THE NEXT FISCAL YEAR. (APR 1984)

Funds are not presently available for performance under this contract beyond September 30, 1985. The Government's obligation for performance of this contract beyond that date is contingent upon the availability of appropriated funds from which payment for contract purposes can be made. No legal liability on the part of the Government for any payment may arise for performance under this contract beyond September 30, 1985 until funds are made available to the Contracting Officer for performance and until the Contractor receives notice of availability, to be confirmed in writing by the Contracting Officer.

(End of clause)

SECTION G CONTRACT ADMINISTRATION DATA

852.270-1 REPRESENTATIVE OF CONTRACTING OFFICER APRIL 1984

The Contracting Officer reserves the right to designate representatives to act for him/her in furnishing technical guidance and advice or to generally supervise the work to be performed under this contract. Such designation will be in writing and will define the scope and limitation of the designee's authority. A copy of the designation shall be furnished the Contractor.

TEMPORARY REGULATION 66 AND SUPPLEMENT #1 OCTOBER 1982

PAYMENT DUE DATE

Payment for goods and services provided or executed under this contract shall be due on the 30th calendar day after the date of receipt of a proper invoice in the designated payment office or the acceptance by the Government of the goods or services required under the contract, whichever is later. Where partial payment is provided for partial executions or deliveries, such individual partial payment shall be due as described above. Payment shall be considered to be made on the date on which a check for payment is dated or a wire transfer is made.

PROPER INVOICE

Invoices submitted for payment for goods or services provided under this contract must include as a minimum, the following:

1. An acceptable copy of the closing statement in the

event of cash sales.

2. An acceptable loan closing package including the closing statement on sales where vendee loans are authorized.

INTEREST ON OVERDUE PAYMENTS

(A) The Prompt Payment Act, Public Law 97-177 (96 Stat. 85, 31 U.S.C. 1801) is applicable to payments under this contract. The act requires the payment to contractors of interest on overdue payment.

(B) An interest penalty will be paid automatically when all of the following conditions are met:

(1) Government acceptance of property or services has occurred, and there is no disagreement over quantity, quality, or other contract provisions.

(2) A proper invoice has been received (except where no invoice is required, e.g., some periodic lease payments).

(3) Payment is made to the contractor more than fifteen (15) days after the due date

(C) An interest penalty will also be paid when an agency takes a discount after the discount period has expired, and fails to correct the underpayment within fifteen (15) days of the expiration of the discount period

(D) Interest penalties are not required when payment is delayed because of payment or other issues concerning compliance with the terms of the contract, nor are they required for a period when amounts are withheld temporarily in accordance with the terms of the contract. Claims concerning disputes, and any interest that may be payable with respect to the period during which the dispute is being settled, will be resolved in accordance with the provisions of the Contract Disputes Act of 1978 (41 U.S.C. 601 ET Seq.).

(E) Interest penalties under the act shall not continue to accrue after the filing of a claim for such penalties under the Contract Disputes Act of 1978, or for more than one year. This provision shall not be construed to preclude the accrual of interest pursuant to Section 12 of the Contract Disputes Act of 1978 (41 U.S.C. 611) after interest penalties have ceased accruing under the Prompt Payment Act, and interest pursuant to such section may accrue on both the unpaid contract payment and on the unpaid interest penalty required by the Prompt Payment Act.

(F) Calculation of interest penalties shall be as follows. Whenever a proper invoice (or periodic payment where no invoice is required) is paid after the due date (determined in accordance with the payment terms set forth in this contract) plus fifteen (15) days interest will be included with the payment at the interest rate applicable on the payment date. Interest will be computed from the day after the due date through the payment date and the amount will be separately stated on the check or accompanying remittance advice. Adjustment will be made for errors in calculating interest if requested. When an interest penalty that is owed is not paid, interest will accure on the unpaid amount until paid. Interest penalties remaining unpaid for any thirty (30) day period will be added to the principal, and interest penalties, thereafter, will accure monthly on the total of the principal and previously accured interest.

(1) When an agency takes a discount after the discount period has expired. The interest payment will be calculated on the amount of the discount taken, for the period beginning the day after the end of the specified discount period through the payment date.

(2) When an agency fails to make notification of an improper invoice within fifteen (15) days, the number of days allowed for payment of the corrected, proper invoice will be reduced by the number of days between the 15th day and the day notification was transmitted to the contractor. Calculation of interest penalties, if any, will be based on an adjusted due date reflecting the reduced number of days allowable for payment.

(3) Interest penalties will be computed at the rate established by the Secretary of The Treasury for interest payments under Section 12 of the Contract Disputes Act of 1978 (41 U.S.C. 611). Daily interest penalties payable pursuant to this clause will be computed on the basis of the actual number of days in the calendar year.

(4) Interest penalties of less than one dollar will not be paid.

DEFINITIONS:

FOR PURPOSES OF THIS SUBPART, THE FOLLOWING DEFINITION SHALL APPLY:

(A) AGENCY. The same meaning as the term "agency" in Section 551
(1) of Title 5, United States Code, and also includes any entity
(1) that is operated exclusively as an instrumentality of such an agency for the purpose of administering one or more programs of that agency, and (2) that is so identified for this purpose by the head of such agency.

(B) APPLICABLE INTEREST RATE. The interest rate established by the Secretary of the Treasury under Section 12 of Contract Disputes Act of 1978 (41 U.S.C. 611) and published in the Federal Register. This rate is referred to as the "Renegotiation Board Interest Rate," and is published semiannually on or about January 1, and July 1.

(C) BUSINESS CONCERN. Any person or organization engaged in a profession, trade, or business; and not for profit entities (including state and local government, but excluding federal entities) operating as contractors.

(D) CONTRACT. Any enforceable agreement, including rental and lease agreements and purchase orders, between an agency and a business concern for the acquisition of property or services.

(E) DESIGNATED PAYMENT OFFICE. The place named in the LETTER OF ASSIGNMENT for forwarding of invoices for payment, or, in certain instances, for approval.

(F) DUE DATE. The date by which federal payment should be made.

(G) PROPER INVOICE. A bill or written request for payment provided by a business concern for property or services rendered. A proper invoice must meet the requirements of Section 8-29.5004-3.

(H) PAYMENT DATE. The date on which a check for payment is dated or a wire transfer is made.

(I) RECEIPT OF INVOICE. The later of:

(1) The date of a proper invoice is actually received in the designated payment office, or

(2) The date on which the agency accepts the property or service.

(K) RECEIVING REPORT. Written evidence of acceptance of property or service by a Government Official.

(L) DELIVERY. The date of delivery of goods or execution of services required under the contract. Delivery is not considered to be complete until a proper invoice is received in the designated payment office.

(M) GRACE PERIOD. The statutorily allowed period following the payment due date during which no interest penalty accrues if payment is made therein. The grace period is fifteen (15) days.

Letter of Assignment

Contract # ___________

The purpose of this letter is to notify you as the auctioneer/contractor under the contract with VA dated ________ that VA will conduct an auction in ________________ during the week of ___________, 19___. Approximately ___________ properties will be included.

Designation of Representative

Contracting Officer's Technical Representative

The contractor shall contact the Contracting Officer on all matters pertaining to administration. Only the Contracting Officer is authorized to make commitments or issue changes which will affect the price, quantity or delivery terms of this contract. The Director, VA Regional Office, ________ is designated as representative of the Contracting Officer in furnishing technical guidance, advice and supervising the work to be performed under this contract. This regional office is also the designated payment office.

Please wire your acceptance of this assignment within 5 days.

Robert M. O'Toole (26)
Contracting Officer
Veterans Administration
810 Vermont Ave. N.W.
Washington, D.C. 20420

____

VA Contracting Officer

____

Date

SECTION H - SPECIAL CONTRACT REQUIREMENTS

FREEDOM OF INFORMATION NOTIFICATION (FOIA)

Please be advised that proposals submitted in response to this solicitation are subject to disclosure under the Freedom of Information Act (FOIA). To assist the VA in determining whether or not to release information contained in a proposal in the event a FOIA request is received, offerors may, through clear earmarking or otherwise, indicate those portions of their proposals which they believe should not be disclosed. While an offeror's advice will be considered by the VA in its determination whether to release requested information or not, it must be emphasized that VA is required by the FOIA to make an independent evaluation as to the release of all information requested and that accordingly, information may be released notwithstanding the offeror's views. It is suggested if an offeror believes that confidential treatment is appropriate, the basis for his view should be provided, where possible, because general assertions or blanket requests for confidentiality, without more, are not particularly helpful to VA in making determinations concerning the release of information under the Act. It should also be noted that VA is required to segregate disclosable information from non-disclosable items, so particular care should be taken in the identification of each portion for which confidential treatment is requested. Offeror's views concerning its confidentiality will be used solely to aid the VA in preparing its response to FOIA requests. Further, offerors should note that the presence or absence of such comments and/or earmarking regarding confidentiality will have no bearing whatsoever on the evaluation of proposals submitted pursuant to this solicitation, nor will the absence of this earmarking automatically result in greater disclosure.

PAYMENT

The contractor's fee on any property shall be considered as earned and payable when:

a. Cash sales - when the sale closes

b. Outside financing - when the sale closes

c. Vendee financing - when an acceptable closing package has been received by VA.

Payment will be made as follows:

a. Cash sales - at closing

b. Outside financing - at closing

c. Vendee financing - upon receipt of an acceptable closing package.

PROMPT PAYMENT DISCOUNTS.

Prompt payment discounts shall not be considered in the evaluation of bids. However, any discount offered will form a part of the award, and will be taken by the payment center if payment is made within the discount period specified by the bidder. As an alternative to indicating a discount in conjunction with the offer, bidders may prefer to offer discounts on individual invoices.

FAILURE OF BUYER TO CLOSE SALE

In the event that a purchase offer is accepted by VA and that purchaser and at least one backup bidder whose bid exceeds the established minimum price on that property should fail to close the sale, the earnest money deposit shall be forfeited and shall be evenly divided between the Contractor and VA. In no event, however, shall the contractor be entitled to receive any amount which would exceed the fee to which he/she would have been entitled had the sale closed.

If there are at least two bidders on the property at the auction and the contractor fails to properly record at least one backup, the contractor forfeits his/her rights to share in any forfeited earnest money on that property.

TERMINATION:

The VA reserves the right to cancel an auction at any time. In the event the VA exercises this right, either in whole or in part, reimbursement will be made in accordance with FAR clause 52.249-4, Termination for Convenience, for allowable expenses incurred by the contractor.

CONFLICT OF INTEREST

During the term of this contract, neither the contractor, nor any of the contractor's officers, employees, agents, subsidiaries or affiliates will directly or indirectly acquire, purchase or participate in the acquisition or purchase of the property, nor negotiate with respect thereto in any capacity other than as prescribed in this contract. In the event of a breach of this provision, VA will have the right to terminate this contract without liability or, at its option, to recover any and all sums paid to the contractor hereunder.

SECTION I - CONTRACT CLAUSES -
(FIXED PRICE - SERVICE CONTRACT)

52.215-02 CLAUSES INCORPORATED BY REFERENCE
(APR. 1984)

This contract incorporates the following clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available.

I FEDERAL ACQUISITION REGULATION (48 CFR CHAPTER) CLAUSES

52.202-01 DEFINITIONS
(APR. 1984)

52.203-05 COVENANT AGAINST CONTINGENT FEES
(APR. 1984)

52.203-01 OFFICIALS NOT TO BENEFIT
(APR. 1984)

52.203-03 GRATUITIES
(APR. 1984)

52.215-01	EXAMINATION OF RECORDS BY COMPTROLLER GENERAL (APR. 1984)
52.215-02	AUDIT-NEGOTIATION (APR. 1984)
52.217-09	OPTION TO EXTEND THE TERM OF THE CONTRACT - SERVICES (APR. 1984)
52.219.06	NOTICE OF TOTAL SMALL BUSINESS SET ASIDE (APR. 1984)
52.219-08	UTILIZATION OF SMALL BUSINESS CONCERNS AND SMALL DISADVANTAGED BUSINESS CONCERNS (APR. 1984)
52.219-13	UTILIZATION OF WOMAN OWNED SMALL BUSINESS (APR. 1984)
52.220-01	PREFERENCE FOR LABOR SURPLUS AREA CONCERNS (APR. 1984)
52.220-03	UTILIZATION OF LABOR SURPLUS AREA CONCERNS (APR. 1984)
52.222-03	CONVICT LABOR (APR. 1984)
52.222-26	EQUAL OPPORTUNITY (APR. 1984)
52.222-35	AFFIRMATIVE ACTION FOR SPECIAL DISABLED AND VIETNAM ERA VETERANS (APR. 1984)

52.222-36	AFFIRMATIVE ACTION FOR HANDICAPPED WORKERS (APR. 1984)
52.223-02	CLEAN AIR AND WATER (APR. 1984)
52.224-01	PRIVACY ACT NOTIFICATION (APR. 1984)
52.229-03	FEDERAL, STATE AND LOCAL TAXES (APR. 1984)
52.232-17	INTEREST (APR. 1984)
52.232-23	ASSIGNMENT OF CLAIMS (APR. 1984)
52.233-01	DISPUTES (APR. 1984)
52.243-01	CHANGES - FIXED PRICE - ALTERNATE 1 (APR. 1984)
52.249-08	DEFAULT (FIXED-PRICE SUPPLY AND SERVICE) (APR. 1984)

52.228-1 BID GUARANTEE April 1984

(a) Failure to furnish a bid guarantee in the proper form and amount with proposal may be cause for rejection of the bid.

(b) The offeror (bidder) shall furnish a bid guarantee in the form of a firm commitment, such as a bid bond, postal money order, certified check, cashier's check, irrevocable letter of credit, or, under Treasury Department regulations, certain bonds or notes of the United States. The Contracting Officer will return bid guarantees, other than bid bonds, (1) to unsuccessful bidder as soon as practicable after the opening of bids, and (2) to the successful bidder after the execution of contractual documents and bonds (including any necessary coinsurance or reinsurance agreements), as required by the bid as accepted.

(c) If the successful bidder, upon acceptance of its bid by the Government within the period specified for acceptance, fails to execute all contractual documents or give a bond(s) as required by the solicitation within the time specified, the Contracting Officer may terminate the contract for default.

(d) Unless otherwise specified in the bid, the bidder will allow sixty (60) days for acceptance of its bid.

(e) In the event the contract is terminated for default, the bidder is liable for any cost of acquiring the work that exceeds the amount of its bid, and the bid guarantee available to offset the difference.

52.228-2 ADDITIONAL BOND SECURITY

The Contractor shall promptly furnish additional security required to protect the Government and persons supplying labor or materials under this contract if-

(a) Any surety upon any bond furnished with this contract becomes unacceptable to the Government;

(b) Any surety fails to furnish reports on its financial condition as required by the Government; or

(c) The contract price is increased so that the penal sum of any bond becomes inadequate in the opinion of the Contracting Officer.

Performance Bond: The successful bidder agrees to furnish within 10 days after receipt of each Letter of Assignment, a performance bond or other acceptable surety as a guaranty of faithful performance of the terms, conditions, and provisions of the contract in a sum equal to $100,000.00 and the furnishing of such guaranty may not be waived.

THIS IS A TOTAL SMALL BUSINESS SET - ASIDE

SIC # 7399 applies. The concern is a small business if, including its affiliates, its average annual receipts for its preceding three fiscal years do not exceed $3.5 million.

52.232-8 DISCOUNTS FOR PROMPT PAYMENT. (APR 1984)
In connection with any discount offered for prompt payment, time shall be computed from (1) the date of completion of performance of the services or delivery of the supplies to the carrier if acceptance is at point of origin, or date of delivery at destination or port of embarkation if delivery and acceptance are at either of these points, or (2) the date the correct invoice or voucher is received in the office specified by the Government, if the latter is later than date of performance or delivery. For the purpose of computing the discount earned, payment shall be considered to have been made on the date the Government check was mailed.

(End of clause)

52.244-1 SUBCONTRACTS UNDER FIXED-PRICE CONTRACTS.
(APR 1984)

(a) This clause does not apply to firm-fixed-price contracts and fixed-price contracts with economic price adjustment. However, it does apply to subcontracts resulting from unpriced modifications to such contracts.

(b) "Subcontract," as used in this clause, includes but is not limited to purchase orders, and changes and modifications to purchase orders. The Contractor shall notify the Contracting Officer reasonably in advance of entering into any subcontract if the Contractor does not have an approved purchasing system and if the subcontract--

(1) Is to be a cost-reimbursement, time-and-materials, or labor-hour contract estimated to exceed $25,000 including any fee;

(2) Is proposed to exceed $100,000; or

(3) Is one of a number of subcontracts with a single subcontractor, under this contract, for the same or related supplies or services, that in the aggregate are expected to exceed $100,000.

(c) The advance notification required by paragraph (b) above shall include--

(1) A description of the supplies or services to be subcontracted;

(2) Identification of the type of subcontract to be used;

(3) Identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected, including the competition obtained;

(4) The proposed subcontract price and the Contractor's cost or price analysis;

(5) The subcontractor's current, complete, and accurate cost or pricing data and Certificate of Current Cost or Pricing Data, if required by other contract provisions;

(6) The subcontractor's Disclosure Statement or Certificate relating to Cost Accounting Standards when such data are required by other provisions of this contract; and

(7) A negotiation memorandum reflecting--

(i) The principal elements of the subcontract price negotiations;

(ii) The most significant considerations controlling establishment of initial or revised prices;

(iii) The reason cost or pricing data were or were not required;

(iv) The extent, if any, to which the Contractor did not rely on the subcontractor's cost of pricing data in determining the price objective and in negotiating the final price;

SECTION K

REPRESENTATIONS CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS

(FIXED PRICE - SERVICE)

52.203-02 CERTIFICATE OF INDEPENDENT PRICE DETERMINATION. (APR. 1984)

(a) The offeror certifies that--

(1) The prices in this offer have been arrived at independently, without, for the purpose of restricting competition, any consultation, communication, or agreement with any other offeror or competitor relating to (i) those prices, (ii) the intention to submit an offer, or (iii) the methods or factors used to calculate the prices offered;

(2) The prices in this offer have not been and will not be knowingly disclosed by the offeror, directly or indirectly, to any other offeror or competitor before bid opening (in the case of a formally advertised solicitation) or contract award (in the case of a negotiated solicitation) unless otherwise required by law, and

(3) No attempt has been made or will be made by the offeror to induce any other concern to submit or not to submit an offer for the purpose of restricting competition.

(b) Each signature on the offer is considered to be a certification by the signatory that the signatory--

(1) Is the person in the offeror's organization responsible for determining the prices being offered in this bid or proposal, and that the signatory has not participated and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above; or

(2) (i) Has been authorized in writing, to act as agent for the following principals in certifying that those principals have not participated, and will not participate in any action contrary to subparagraphs (a)(1) through (a)(3) above........................

(insert full name of persons(s) in the offeror's organization responsible for determining the prices offered in this bid or proposal, and the title of his or her position in the offeror's organization).

(ii) As an authorized agent, does certify that the principals named in subdivision (b)(2)(i) above have not participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above; and

(iii) As an agent, has not personally participated, and will not participate, in any action contrary to subparagraphs (a)(1) through (a)(3) above.

(c) If the offeror deletes or modifies subparagraph (a)(2) above, the offeror must furnish with its offer a signed statement setting forth in detail the circumstances of the disclosure.

(End of Provision)

52.203-04 CONTINGENT FEE REPRESENTATION AND AGREEMENT.

(APR. 1984)

(a) Representation. The offeror represents that, except for fulltime bona fide employees working solely for the offeror, the offeror--

Note: The offeror must check the appropriate boxes. For interpretation of the representation, including the term "bona fide employee," see Subpart 3.4 of the Federal Acquisition Regulation.

(1) __ has, X has not employed or retained any person or company to solicit or obtain this contract; and

(2) __ has, X has not paid or agreed to pay to any person or company employed or retained to solicit or obtain this contract any commission, percentage, brokerage, or other fee contingent upon or resulting from the award of this contract.

(b) Agreement. The offeror agrees to provide information relating to the above Representation as requested by the Contracting Officer and, when subparagraph (a)(1) or (a)(2) is answered affirmatively, to promptly submit to the Contracting Officer--

(1) A completed Standard Form 119, Statement of Contingent or Other Fees, (SF 119); or

(2) A signed statement indicating that the SF 119 was previously submitted to the same contracting office, including the date and applicable solicitation or contract number, and representing that the prior SF 119 applies to this offer or quotation.

(End of provision)

52.215-06 TYPE OF BUSINESS ORGANIZATION.
(APR. 1984)

The offeror or quoter, by checking the applicable box, represents that it operates as X a corporation incorporated under the laws of the State of ALABAMA, __ a nonprofit organization, or __ a joint venture.

(End of provision)

52.215-11 AUTHORIZED NEGOTIATORS.
(APR. 1984)

The offeror or quoter represents that the following persons are authorized to negotiate on its behalf with the Government in connection with this request for proposals or quotations: list names, titles, and telephone numbers of the authorized negotiators.

52.214-08 PARENT COMPANY AND IDENTIFYING DATA.
(APR. 1984)

(a) A "parent" company, for the purpose of this provision, is one that owns or controls the activities and basic business policies of the bidder. To own the bidding company means that the parent company must own more than 50 percent of the voting rights in that company. A company may control a bidder as a parent even though not meeting the requirement for such ownership if the parent company is able to formulate, determine, or veto basic policy decisions of the offeror through the use of dominant minority voting rights, use of proxy voting, or otherwise.

(b) The bidder __ is, X is not (check applicable box) owned or controlled by a parent company.

(c) If the bidder checked "is" in paragraph (b) above, it shall provide the following information:

Name and Main Office Address of Parent Company (Include Zip Code)	Parent Company's Employer's Identification Number
....	....
....	....
....	....

(d) If the bidder checked "is not" in paragraph (b) above, it shall insert its own Employer's Identification Number of on the following line: 63-0879232

(End of provision)

52.215-20 PLACE OF PERFORMANCE
(APR. 1984)

(a) The offeror or quoter, in the performance of any contract resulting from this solicitation, __ intends, __ does not intend (check applicable block) to use one or more plants or facilities located at a different address from the address of the offeror or quoter as indicated in this porposal or quotation.

(b) If the offeror or quoter checks "intends" in paragraph (a) above, it shall insert in the spaces provided below the required information:

Place of Performance (Street Address, City, County, State, Zip Code)	Name and Address of Owner and Operator of the Plant or Quoter
....	....
....	....
....	....

(End of provision)

52.219-10 SMALL BUSINESS CONCERN REPRESENTATION. (APR. 1984)

The offeror represents and certifies as part of its offer that it X is, ___ is not a small business concern and that X all, ___ not all supplies to be furnished will be manufactured or produced by a small business concern in the United States, its possessions, or Puerto Rico. "Small business concern," as used in this provision, means a concern, including its affiliates, that is independently owned and operated, not dominant in the field of operation in which it is bidding on Government contracts, and qualified as a small business under the size standards in this solicitation.

(End of provision)

52.219-02 SMALL DISADVANTAGED BUSINESS CONCERN REPRESENTATION.

(APR. 1984)

(a) Representation. The offeror represents that it __ is, X is not a small disadvantaged business concern.

(b) Definitions. "Asian-Indian American," as used in this provision, means a United States citizen whose origins are in India, Pakistan, or Bangladesh. Asian-Pacific Americans means those citizens whose origins are in Japan, China, the Philippines, Vietnam, Korea, Samoa, Guam, the U.S. Trust Territory of the Pacific Islands, the Northern Mariana Islands, Laos, Cambodia, or Taiwan. "Native Americans," as used in this provision, means American Indians, Eskimos, Aleuts, and native Hawaiians.

"Small business concern," as used in this provision, means a concern, including its affiliates, that is independently owned and operated, not dominant in the field of operation in which it is bidding on Government contracts, and qualified as a small business under the criteria and size standards in 13 CFR 121. "Small disadvantaged business concern," as used in this provision, means a small business concern that (1) is at least 51 percent owned by disadvantaged, or a publicly owned business having at least 51 percent disadvantaged individuals and (2) has its management and daily business controlled by one or more such individuals.

(c) Qualified groups. The offeror shall presume that socially and economically disadvantaged individuals include Black Americans, Hispanic Americans, Native Americans, Asian-Pacific Americans, Asian-Indian Americans, and other individuals found to be qualified by the SBA Under 13 CRF 124.1.

(End of provision)

52.219-03 WOMEN-OWNED SMALL BUSINESS REPRESENTATION.
(APR. 1984)

(a) Representation. The offeror represents that it ___ is, X is not a women-owned business concern.

(b) Definitions. "Small business concern," as used in this provision, means a concern, including its affiliates, that is independently owned and operated, not dominant in the field of operation in which it is bidding on government contracts, and qualified as a small business under the criteria and size standards in 13 CFR 121.

"Women-owned," as used in this provision, means a small business that is at least 51 percent owned by a woman or women who are U.S. citizens and who also control and operate the business.

(End of provision)

52.222-19 WALSH-HEALEY PUBLIC CONTRACTS ACT REPRESENTATION.
(APR. 1964)

The offeror represents as a part of this offer that the offeror is

X or is not __ a regular dealer in, or is _ or is not __ a manufacturer of, the supplies offered.

(End of provision)

52.222-21 CERTIFICATION OF NONSEGREGATED FACILITIES.
(APR. 1984)

(a) "Segregated facilities," as used in this provision, means any waiting rooms, work areas, rest rooms and wash rooms, restaurants and other eating areas, time clocks, locker rooms and other storage or dressing areas, parking lots, drinking fountains, recreation or entertainment areas, transportation, and housing facilities provided for employees, that are segregated by explicit directive or are in fact segregated on the basis of race, color, religion, or national origin because of habit, local custom, or otherwise.

(b) By the submission of this offer, the offeror certifies that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not and will not permit its employees to perform their services at any location under its control where segregated facilities are maintained. The offeror agrees that a breach of this certification is a violation of the Equal Opportunity clause in the contract.

(c) The offeror further agrees that (except where it has obtained identical certifications from proposed subcontractors for specific time periods) it will--

(1) Obtain identical certifications from proposed subcontractors before the award of subcontracts under which the subcontractor will be subject to the Equal Opportunity clause;

(2) Retain the certifications in its files; and

(3) Forward the following notice to the proposed subcontractors (except if the proposed subcontractors have submitted identical certifications for specific time periods):

NOTICE TO PROSPECTIVE SUBCONTRACTORS OF REQUIREMENT FOR CERTIFICATIONS OF NONSEGREGATED FACILITIES

A Certification of Nonsegregated Facilities must be submitted before the award of a subcontract under which the subcontractor will be subject to the Equal Opportunity clause. The certification may be submitted either for each subcontract or for all subcontracts during a period (i.e., quarterly, semiannually, or annually).

NOTE: The penalty for making false statements in offers is prescribed in 18 U.S.C. 1001.

(End of provision)

52.222-22 PREVIOUS CONTRACTS AND COMPLIANCE REPORTS.
(APR. 1984)

The offeror represents that--

(a) It X has, __ has not participated in a previous contract or subcontract subject either to the Equal Opportunity clause of this solicitation, the clause originally contained in Section 310 of Executive Order No. 10925, or the clause contained in Section 201 of Executive Order No. 11114;

(b) It X has, __ has not, filed all required compliance reports; and

(c) Representations indicating submission of required compliance reports, signed by proposed subcontractors, will be obtained before subcontract awards.

(End of provision)

52.222-25 AFFIRMATIVE ACTION COMPLIANCE.
(APR. 1984)

The offeror represents that (a) it X has developed and has on file, __ has not developed and does not have on file, at each establishment, affirmative action programs required by the rules and regulations of the Secretary of Labor (41 CFR 60-1 and 60-2), or (b) it __ has not previously had contracts subject to the written affirmative action programs requirement of the rules and regulations of the Secretary of Labor.

(End of provision)

52.223-01 CLEAN AIR AND WATER CERTIFICATION.
(APR. 1984)

The Offeror certifies that--

(a) Any facility to be used in the performance of this proposed contract is __, is not X listed on the Environmental Protection Agency List of Violating Facilities;

(b) The Offeror will immediately notify the Contracting Officer, before award, of the receipt of any communication from the Administrator, or a designee, of the Environmental Protection Agency, indicating that any facility that the Offeror proposes to use for the performance of the contract is under consideration to be listed on the EPA List of Violating Facilities; and

(c) The Offeror will include a certification substantially the same as this certification, including this paragraph (c), in every nonexempt subcontract.

(End of provision)

52.225-01 BUY AMERICAN CERTIFICATE.
(APR. 1984)

The offeror certifies that each end product, except those listed below, is a domestic end product (as defined in the clause entitled "Buy American Act--Supplies"), and the components of unknown origin are considered to have been mined, produced, or manufactured outside the United States.

Excluded End Product	Country of Origin
....	....
....	....
....	....

(List as necessary)

Offerors may obtain from the contracting officer lists of articles, materials, and supplies excepted from the Buy American Act (Listed at 25.108 of the Federal Acquisition Regultion).

(End of Provision)

SECTION L

INSTRUCTIONS CONDITIONS AND NOTICES TO OFFER

(FIXED PRICE SERVICE)

52.252-01 SOLICITATION PROVISIONS INCORPORATED BY REFERENCE (APR. 1984)

This solicitation incorporates the following provisions by reference, with the same force and effect as if they were given in full text. Upon request the Contracting Officer will make their full text available.

I FEDERAL ACQUISTION REGULATION (48 CFR CHAPTER I CLAUSES)

52.215-05 SOLICITATION DEFINITIONS
(APR. 1984)

52.215-07 UNNECESSARILY ELABORATE PROPOSALS OR QUOTATIONS
(APR. 1984)

52.215-08 ACKNOWLEDGEMENT OF AMENDMENTS TO SOLICITATIONS
(APR. 1984)

52.215-09 SUBMISSION OF OFFERS
(APR. 1984)

52.215-10 LATE SUBMISSION MODIFICATIONS, AND WITHDRAWALS OF PROPOSALS
(APR. 1984)

52.215-12 RESTRICTION ON DISCLOSURE AND USE OF DATA
(APR. 1984)

52.215-13 PREPARATION OF OFFERS
(APR. 1984)

52.215-14 EXPLANATION TO PROSPECTIVE OFFERORS
(APR. 1984)

52.215-15 FAILURE TO SUBMIT OFFER
(APR. 1984)

52.215-16 CONTRACT AWARD
(APR. 1984)

52.215-18 ORDER OF PRECEDENCE
(APR. 1984)

TECHNICAL QUESTIONS

Offerors should submit all technical questions concerning this solicitation in writing as soon as possible after receipt of this package. The VA will answer question which may affect offers in an amendment to the solicitation. The VA will not reference the source of any such questions.

CERTIFICATION FOR THE ETHICS IN GOVERNMENT ACT

(April 84)

The offeror certifies that in developing a proposal in response to the solicitation of this contract, he/she did not utilize the services of any former Veterans Administration employee acting in violation of Title V of the Ethics in Government Act, 18 U.S.C. 207. That law provides that:

(a) A former Veterans Administration employee who, as such an employee, personally and substantially participated in a particular procurement process, is prohibited from appearing before the agency on behalf of an offeror responding to a solicitation resulting from that process and from making any contact with the agency on behalf of the offeror with intent of influencing action related to the solicitation;

(b) A former Veterans Administration employee who, during the last year as such an employee, was officially responsible for a particular procurement process, is prohibited, for two years after leaving the Veterans Administration, from appearing before the agency on behalf of an offeror responding to a solicitation resulting from that process and from making any contact with the agency on behalf of the offeror with the intent of influencing action related to the solicitation;

(c) Any former top-level Veterans Administration employee (i.e., executive-level employee; employee paid at the rate of GS-17 or above if designated pursuant to 5 CFR 737.25(b); and Senior Executive Service employee if designated pursuant to 5 CFR

737.25(b)) who, as such an employee, personally and substantially participated in a particular procurement process, is prohibited, for a period of two years, from representing, aiding, consulting, or assisting an offeror by his/her presence before the Government at any formal or informal appearance related to that procurement process;

(d) For a period of one year, any former top-level employee of the Veterans Administration (as described in the preceding paragraph) is prohibited from appearing before the Veterans Administration on behalf of any offeror responding to a contract solicitation and is prohibited from making any oral or written communications with the Veterans Administration on behalf of such an offeror, with the intent of influencing action related to a contract.

§ 852.236-76 Correspondence.

All correspondence relative to this contract shall bear the. Veterans Administration Contract Number, title of project and name of station.

§ 852.270-4 Commercial advertising.

The bidder agrees that if a contract is awarded to him/her, as a result of this solicitation, he/she will not advertise the award of the contract in his/her commercial advertising in such a manner as to state or imply that the Veterans Administration endorses a product, project or commercial line of endeavor.

SECTION M - EVALUATION FACTORS FOR AWARD

1. Evaluation criteria

   A. General

      1. Factors that will be used to evaluate this proposal.

         a) Marketing Approach
         b) Relevant Organizational Capability
         c) Personnel

      2. Price

The marketing approach will be the most important single consideration in the award of the contract and should, therefore, be as complete and as specific as possible. The evaluation will be based on the marketing and administration capabilities of prospective contractors in relation to the needs necessary to conduct real estate auctions involving 75 properties or more. The specific evaluation factors, with regard to this particular contract, are as follows:

Factors that will be used to Evaluate the Marketing Proposal

Proposals submitted in response to this RFP shall be evaluated in accordance with the following factors with a maximum total score of 100 points.

a) Marketing approach 45 points

The marketing proposal should clearly demonstrate a thorough understanding of the real estate auction process and the tasks that must be performed to create maximum public interest and insure large turnouts of prospective purchasers for the auctions. The marketing plans should clearly explain the methods to be used to assure results in terms of creating widespread public interest in all three real estate markets which have distintively different economical and social conditions. The proposal should include the results of several previous marketing plans that involved auctions where at least 75 properties were sold.

b) Relevant Organizational Capability 30 points

The contractor's capability and professional skills associated with the auction of real property throughout the United States and the contractors experience in conducting real estate auctions involving large number of properties involving different real estate markets will be evaluated.

c) Personnel 10 points

The experience and qualifications of the offeror's personnel who will be assigned to conduct the auction and manage the pre-auction office that is required in the offering.

d) Price 15 points

The price proposals will be evaluated in accordance with the following formula with a total possible score of 15 points. The lowest price of those offerors whose technical evaluation places them in the competitive range will receive the full 15 points and each other offeror in the competitive range will receive a percentage of the 15 points based on the ratio of their price to the lowest price.

Example of price evaluation:
Low price - 5% = 15 points
Offeror A - 6% 5÷6 x 15 = 12.50 points

Basis for Award

Award will be made to the offeror who has the highest total evaluation score and who has been determined to be responsible by the contracting officer.

AMENDMENT OF SOLICITATION/MODIFICATION OF CONTRACT

1. CONTRACT ID CODE

PAGE 1 OF PAGES 3

2. AMENDMENT/MODIFICATION NO. #1

3. EFFECTIVE DATE 2/6/85

4. REQUISITION/PURCHASE REQ. NO.

5. PROJECT NO. (If applicable)

6. ISSUED BY CODE (263)

Veterans Administration
810 Vernmont Ave. NW
Washington, DC 20420

7. ADMINISTERED BY (If other than Item 6) CODE

8. NAME AND ADDRESS OF CONTRACTOR (No., street, county, State and ZIP Code)

Larry Latham Auctioneers, Inc.
P. O. Box 201
Moulton, Al 35650

CODE

FACILITY CODE

(✓) X 9A. AMENDMENT OF SOLICITATION NO. 26/101/1

9B. DATED (SEE ITEM 11) 1/24/85

10A. MODIFICATION OF CONTRACT/ORDER NO.

10B. DATED (SEE ITEM 13)

11. THIS ITEM ONLY APPLIES TO AMENDMENTS OF SOLICITATIONS

☒ The above numbered solicitation is amended as set forth in Item 14. The hour and date specified for receipt of Offers ☐ is extended, ☒ is not extended.

Offers must acknowledge receipt of this amendment prior to the hour and date specified in the solicitation or as amended, by one of the following methods:

(a) By completing Items 8 and 15, and returning 2 copies of the amendment; (b) By acknowledging receipt of this amendment on each copy of the offer submitted; or (c) By separate letter or telegram which includes a reference to the solicitation and amendment numbers. FAILURE OF YOUR ACKNOWLEDGMENT TO BE RECEIVED AT THE PLACE DESIGNATED FOR THE RECEIPT OF OFFERS PRIOR TO THE HOUR AND DATE SPECIFIED MAY RESULT IN REJECTION OF YOUR OFFER. If by virtue of this amendment you desire to change an offer already submitted, such change may be made by telegram or letter, provided each telegram or letter makes reference to the solicitation and this amendment, and is received prior to the opening hour and date specified.

12. ACCOUNTING AND APPROPRIATION DATA (If required)

13. THIS ITEM APPLIES ONLY TO MODIFICATIONS OF CONTRACTS/ORDERS, IT MODIFIES THE CONTRACT/ORDER NO. AS DESCRIBED IN ITEM 14.

(✓)

A. THIS CHANGE ORDER IS ISSUED PURSUANT TO: (Specify authority) THE CHANGES SET FORTH IN ITEM 14 ARE MADE IN THE CONTRACT ORDER NO. IN ITEM 10A.

B. THE ABOVE NUMBERED CONTRACT/ORDER IS MODIFIED TO REFLECT THE ADMINISTRATIVE CHANGES (such as changes in paying office, appropriation date, etc.) SET FORTH IN ITEM 14, PURSUANT TO THE AUTHORITY OF FAR 43.103(b).

C. THIS SUPPLEMENTAL AGREEMENT IS ENTERED INTO PURSUANT TO AUTHORITY OF:

D. OTHER (Specify type of modification and authority)

E. IMPORTANT: Contractor ☒ is not, ☐ is required to sign this document and return ________ copies to the issuing office.

14. DESCRIPTION OF AMENDMENT/MODIFICATION (Organized by UCF section headings, including solicitation/contract subject matter where feasible.)

This solicitation is amended per the attached document labeled
Amendment #1
RFP 26/101/1

Except as provided herein, all terms and conditions of the document referenced in Item 9A or 10A, as heretofore changed, remains unchanged and in full force and effect.

15A. NAME AND TITLE OF SIGNER (Type or print)

16A. NAME AND TITLE OF CONTRACTING OFFICER (Type or print)
Robert M. O'Toole (26)
Director, Loan Guaranty Service

15B. CONTRACTOR/OFFEROR

(Signature of person authorized to sign)

15C. DATE SIGNED

16B. UNITED STATES OF AMERICA

BY Robert M. O'Toole

(Signature of Contracting Officer)

16C. DATE SIGNED MAR 06 1985

Amendment #1

RFP 26/101/1

I. Attached is a copy of SF 24 to be used by those offerors who choose this method of providing the bid bond required in 52.228.1.

II. OPTION TO EXTEND THE TERM OF THE CONTRACT - SERVICE (Apr 1984) (52.217.09) was incorporated by reference in the original RFP but is reproduced in full text below:

OPTION TO EXTEND THE TERM OF THE CONTRACT - SERVICES (APR 1984)

a. The Government may extend the term of this contract by written notice to the Contractor within the time specified in the Schedule; provided, that the Government shall give the Contractor a preliminary written notice of its intent to extend at least 60 days before the contract expires. The preliminary notice does not commit the Government to an extension.

b. If the Government exercises this option, the extended contract shall be considered to include this option provision.

c. The total duration of this contract, including the exercise of any options under this clause, shall not exceed 3 years.

End of clause

TELEGRAPHIC MESSAGE

NAME OF AGENCY VACO	PRECEDENCE ACTION P INFO	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED 3/5/85	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME JOE WHITE	PHONE NUMBER (202) 389-3214	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO: LARRY LATHAM AUCTIONEERS, INC.
P.O. Box 201
MOULTON, AL 35650

MAR 7 1985

LETTER OF ASSIGNMENT

CONTRACTOR: LARRY LATHAM AUCTIONEERS, INC. CONTRACT #: 26/101/1

THE PURPOSE OF THIS WIRE IS TO NOTIFY YOU AS THE AUCTIONEER/CONTRACTOR UNDER THE CONTRACT WITH VA DATED 3/6/85 THAT VA WILL CONDUCT AN AUCTION IN HOUSTON, TX DURING THE WEEK OF JUNE 3, 1985. APPROXIMATELY 150 PROPERTIES WILL BE INCLUDED.

DESIGNATION OF REPRESENTATIVE

CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE

THE CONTRACTOR SHALL CONTACT THE CONTRACTING OFFICER ON ALL MATTERS PERTAINING TO ADMINISTRATION. ONLY THE CONTRACTING OFFICER IS AUTHORIZED TO MAKE COMMITMENTS OR ISSUE CHANGES WHICH WILL AFFECT THE PRICE, QUANTITY OR DELIVERY TERMS OF THIS CONTRACT. THE DIRECTOR, VA REGIONAL OFFICE, HOUSTON IS DESIGNATED AS REPRESENTATIVE OF THE CONTRACTING OFFICER IN FURNISHING TECHNICAL GUIDANCE, ADVICE AND SUPERVISING THE WORK TO BE PERFORMED UNDER THIS CONTRACT. THIS REGIONAL OFFICE IS ALSO THE DESIGNATED PAYMENT OFFICE.

Robert M. O'Toole
VA CONTRACTING OFFICER
MAR 7 1985
DATE

PAGE NO.	NO. OF PGS.	SECURITY CLASSIFICATION
1	2	

STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

U.S. GOVERNMENT PRINTING OFFICE : [illegible]

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO.	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED (*Use double spacing and all capital letters*)

TO:

PLEASE WIRE YOUR ACCEPTANCE OF THIS ASSIGNMENT WITHIN FIVE(5) DAYS TO:

ROBERT M. O'TOOLE (26)
CONTRACTING OFFICER
VETERANS ADMINISTRATION
810 VERMONT AVE. N.W.
WASHINGTON, D.C. 20420

Robert M. O'Toole

PAGE NO.	NO. OF PGS.	SECURITY CLASSIFICATION
2	2	

STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

U.S. GOVERNMENT PRINTING OFFICE : [illegible]

NOV 6 1985

Larry Latham Auctioneers, Inc.
P. O. Box 201
Moulton, AL 35650

SUBJ: Letter of Assignment
Contract Number: 26/101/1

Dear Mr. Latham:

The purpose of this letter is to notify you, as the auctioneer/contractor under the contract with VA dated March 6, 1985, that VA will conduct an auction in the Houston, Texas region on February 15 and 16, 1986. This auction will include approximately 200-250 properties.

The Director, VA Regional Office, Houston is designated as the representative of the Contracting Officer in furnishing technical guidance, advice and supervising the work to be performed under this contract assignment. The contractor shall contact the Contracting Officer (attn: Mr. Joe White) on all matters pertaining to administration. Only the Contracting Officer is authorized to make commitments or issue changes which will affect the price, quantity or delivery terms of this contract. Enclosed are two copies of the Delegation of Authority naming the Director as the Contracting Officer's Technical Representative (COTR). Please acknowledge by dating, signing, and returning one copy for our files. The Houston office is also the designated payment office under this assignment.

Please wire your acceptance of this assignment within five (5) days to:

Robert K. O'Toole (26)
Contracting Officer
Veterans Administration
810 Vermont Ave, NW
Washington, DC 20420

The following is a list of significant contract events and their deadlines, leading to the auction on February 15 and 16, 1986.

December 15, 1985 - COTR advises auctioneer of auction area and provides him a list of VA management brokers in that area.

READ FOR
FILE

NOV 3 1985

Loan Guaranty Service
Per pc

2.

Larry Latham Auctioneers, Inc.

January 15, 1986 - Auctioneer submits marketing budget to COTR.

January 15, 1986 - COTR submits a list of properties to be auctioned to the auctioneer.

February 1, 1986 - Auctioneer to open an office in the local area by this date.

February 15-16, 1986 - Auction dates.

Sincerely yours,

ROBERT M. O'TOOLE
Director
Loan Guaranty Service

SIGNED

NOV 6 1985

ROBERT M. O'TOOLE

cc: Director (00), VARO, Houston, TX

TWM

JWHITE:rsw:pc 11/5/85 263 26

HOUSTON AUCTION
OF
VETERAN'S ADMINISTRATION PROPERTIES

June 7 & 8, 1985

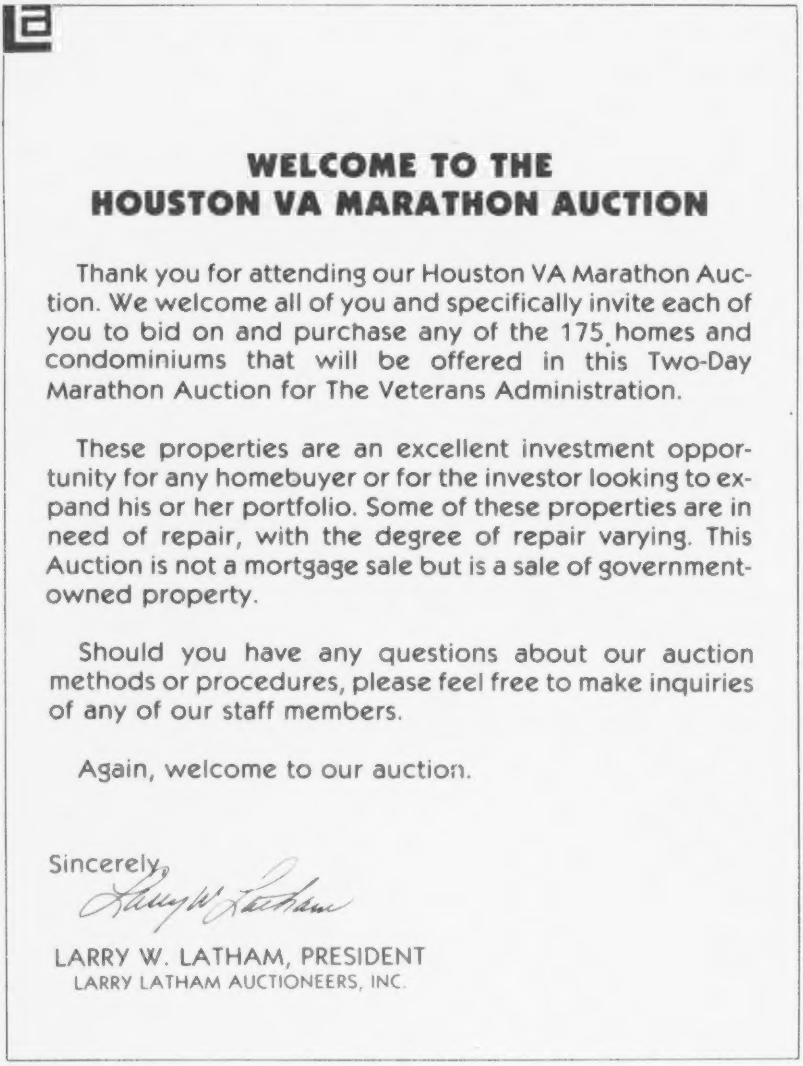
LARRY LATHAM AUCTIONEERS, INC.
10101 SOUTH LOOP FREEWAY WEST, 1 STERLING PLAZA
HOUSTON, TEXAS
PHONE 713/541-0933

AUCTION INFORMATION

DATES: JUNE 7 & 8, 1985
TIMES:
JUNE 7 — 7:00 P.M.
JUNE 8 — 10:00 A.M.
LOCATION: ASTRO VILLAGE HOTEL
2350 South Loop West, Houston
REGISTRATION:
JUNE 7 — 5:00 p.m.
JUNE 8 — 9:00 a.m.

AUCTION HOT LINE

713/541-0933



WELCOME TO THE HOUSTON VA MARATHON AUCTION

Thank you for attending our Houston VA Marathon Auction. We welcome all of you and specifically invite each of you to bid on and purchase any of the 175 homes and condominiums that will be offered in this Two-Day Marathon Auction for The Veterans Administration.

These properties are an excellent investment opportunity for any homebuyer or for the investor looking to expand his or her portfolio. Some of these properties are in need of repair, with the degree of repair varying. This Auction is not a mortgage sale but is a sale of government-owned property.

Should you have any questions about our auction methods or procedures, please feel free to make inquiries of any of our staff members.

Again, welcome to our auction.

Sincerely,

Larry W. Latham

LARRY W. LATHAM, PRESIDENT
LARRY LATHAM AUCTIONEERS, INC.

INVITATION TO BID

The Staff of Larry Latham Auctioneers, Inc. welcomes you to our Houston VA Marathon Auction. To help you feel more comfortable tonight, the following is a brief outline of our Auction process:

1. All Bidders are to register at the door prior to entering the Auditorium. You will be required to show your Certified Funds, "Postal Money Order or Cashier's Checks from any local banking institution" made payable to (The Veterans Administration). After your check has been shown to the clerk, you will be given a Bidder Card with an assigned number on it. Please keep your Bidder Card, because this will be your number for the Auction that evening and the following morning. You cannot bid without a Bidder Card.

2. Because of the large crowd expected, each registered Bidder may only have one guest in the Bidder's Section of the auditorium.

3. The Auctioneer will make all the necessary announcements covering the Auction procedures and any changes that may need to be made prior to taking the first bid. All announcements made at the Auction take precedence over all printed material.

4. The Auctioneer will invite any questions or inquiries prior to taking the first bid.

5. The bidding will begin with House #1. The Auctioneer will ask for any opening bid. If you would like to bid, simply raise your Bidder Card in the air and shout your bid to the Auctioneer or the Ringman nearest you. Each time the Auctioneer will give the last bid and ask for the next highest dollar bid. As each house comes under the auction gavel, the house number and address will be announced and a color slide will be shown for reference. The houses will be auctioned in the same sequence as they appear in this catalogue.

6. Bidding will continue on each house until all bidding ceases, and the house will be sold to the highest final Bidder. The Auctioneer shall determine if a tie-bid has occurred and will make the final determination as to whether to re-open the bidding and break the tie. VA reserves the right to accept or reject all final bids. After the final bid has been taken, the Auctioneer will again state the property address, your Bidder Card Number and the Final Sales Price which will contractually bind you as the Purchaser.

7. If you have been the successful Bidder, **you will go immediately to the Closing Room** and sign all necessary Documents to obtain your property. At that time, you will turn in your $2,500 Bid Card, make your $2,500 Downpayment and schedule a Closing Appointment within 30 days to pay the balance of the purchase price and receive your deed. If $2,500 is less than 10% of purchase price, you must deposit the balance to achieve a total 10% by 5:00 P.M. on Tuesday, June 11, 1985. If you intend to bid on other properties, a Ringman will bring the necessary information to you and stamp or pickup your Bid Card along with the Certified Check or Cashier's Check and give you a receipt. He will also request that you sign the appropriate Documents. Immediately after the Auction, you must schedule a Closing Date with the Closing Agent.

AUCTION TERMS AND CONDITIONS OF SALE

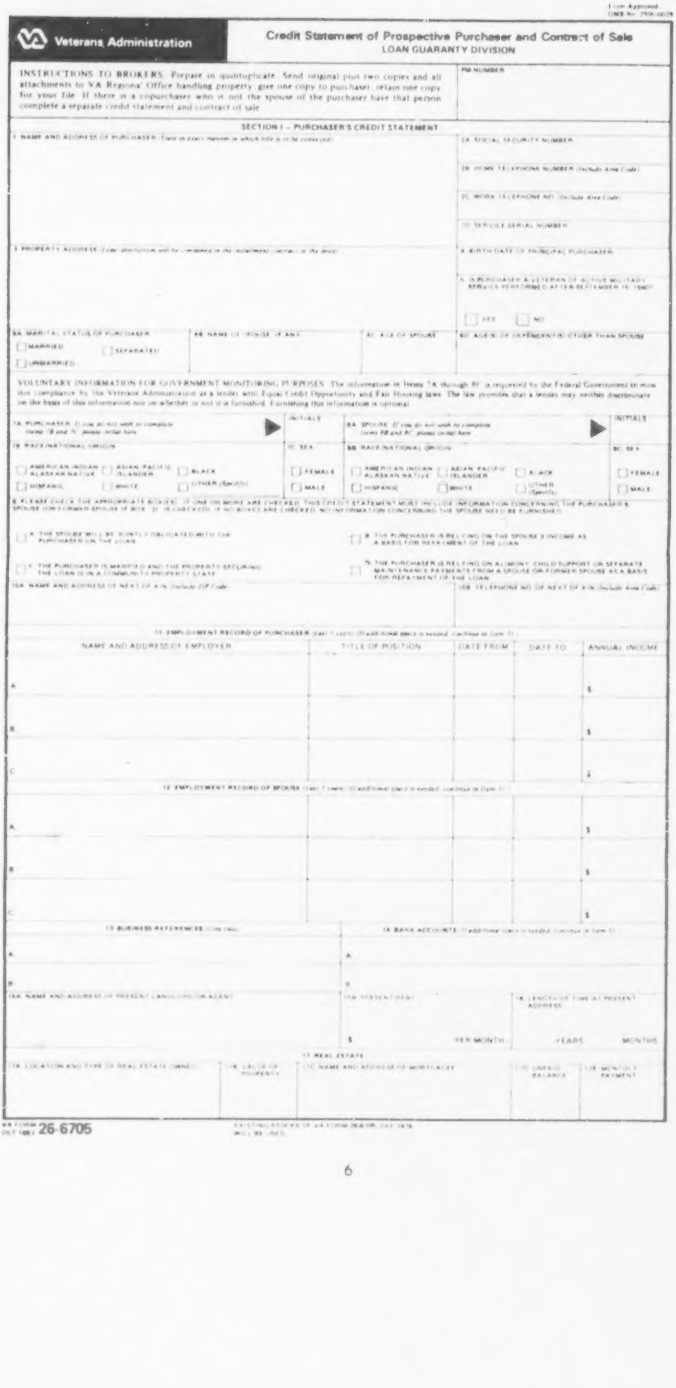
1. All bidding is open to the public without regard to race, color, sex, religion or national origin. All sales will be cash "as is" closing within 30 days. Employees of the Houston VA Regional Office and its affiliates, employees of Larry Latham Auctioneers, Inc. and its affiliates, are specifically prohibited from bidding on or purchasing any property offered in this sale.
2. In order to obtain a bidder's card, you will be required to show to the clerk your Cashier's or Certified Check or cash in the amount of $2,500. All checks are to be payable to "The Veterans Administration". You must have a separate check in the amount of $2,500 for **each** single-family dwelling or condominium that you wish to purchase.
3. Upon request, you may receive a special Investor Bid Card by presenting a $20,000 Cashier's or Certified Check to the clerk. Investor bid cards will enable you to purchase up to 10 single family homes or condominiums. The $20,000 deposit will apply to homes closed in reverse order, beginning with the last closing scheduled. If $20,000 is less than 10% of the combined total purchase price of all homes purchased the investor must deposit the balance to achieve the total 10% by 5:00 P.M. on Tuesday, June 11, 1985.
4. Only the successful high bidder on each property will be required to deposit with VA the Certified or Cashier's Check in the amount of $2,500 for each house or condominium.
5. The successful bidder must sign all documents and contracts **immediately upon the conclusion of bidding on each property.** If your bid is accepted, you will be required to make an appointment with the closing agent to pay the balance of your purchase price and receive the deed to your property. Closings for all properties without financing will be scheduled before June 17, 1985. Payment in full must be made or the downpayment will be forfeited. All properties with sufficient proof of application for financing at closing (mortgage application or bank letter) must close by 5:00 P.M. on July 8, 1985, or the downpayment will be forfeited.
6. All final bids are subject to acceptance by The Veterans Administration. While we feel that all reasonable offers will be entertained, VA retains the right to accept or reject all final bids. There is no minimum opening bid on any property.
7. Real estate taxes, water district charges and maintenance association fees will be prorated as of date of closing. All closing costs are at the sole expense of the purchaser. A closing charge of $180 per property will be due at closing.
8. Announcements made on the day of the auction will take precedence over all printed material. Method, order of sale and bidding increments shall be at the sole discretion of the auctioneer. Re-opening of tie bids shall be determined by the auctioneer.
9. Alternate financing is available to qualified buyers. For information on obtaining this financing call 713-541-0933.
10. VA and Larry Latham Auctioneers, Inc. assume the bidders have inspected the property prior to auction date. These properties are offered for sale **"AS IS — WHERE IS"**, unrepaired and without any expressed or implied warranties. Larry Latham Auctioneers, Inc. assumes no liability for errors or omissions in this or any other property listing or advertising or promotional/publicity statements and material. Although information has been obtained from sources deemed reliable, the auctioneer makes no guarantee as to the accuracy of the information herein contained or in any other property listing or advertising or promotional/publicity statements and material.

5090

Veterans Administration

EQUAL HOUSING
OPPORTUNITY

The following Documents are required for the purchase of VA Single Family Homes. These documents will be furnished to the successful Bidder on each property by our Closing Agent at time of sale.



Form Approved
OMB No. 2900-0029

Veterans Administration

Credit Statement of Prospective Purchaser and Contract of Sale
LOAN GUARANTY DIVISION

INSTRUCTIONS TO BROKERS: Prepare in quintuplicate. Send original plus two copies and all attachments to VA Regional Office handling property; give one copy to purchaser; retain one copy for your file. If there is a copurchaser who is not the spouse of the purchaser have that person complete a separate credit statement and contract of sale.

PM NUMBER

SECTION I – PURCHASER'S CREDIT STATEMENT

1. NAME AND ADDRESS OF PURCHASER *(Type in exact manner in which title is to be conveyed)*

2A. SOCIAL SECURITY NUMBER

2B. HOME TELEPHONE NUMBER *(Include Area Code)*

2C. WORK TELEPHONE NO. *(Include Area Code)*

2D. SERVICE SERIAL NUMBER

3. PROPERTY ADDRESS *(Legal description will be contained in the installment contract or the deed)*

4. BIRTH DATE OF PRINCIPAL PURCHASER

5. IS PURCHASER A VETERAN OF ACTIVE MILITARY SERVICE PERFORMED AFTER SEPTEMBER 16, 1940?
☐ YES ☐ NO

6A. MARITAL STATUS OF PURCHASER
☐ MARRIED ☐ SEPARATED
☐ UNMARRIED

6B. NAME OF SPOUSE IF ANY

6C. AGE OF SPOUSE

6D. AGE(S) OF DEPENDENT(S) OTHER THAN SPOUSE

VOLUNTARY INFORMATION FOR GOVERNMENT MONITORING PURPOSES. The information in Items 7A through 8C is requested by the Federal Government to monitor compliance by the Veterans Administration as a lender with Equal Credit Opportunity and Fair Housing laws. The law provides that a lender may neither discriminate on the basis of this information nor on whether or not it is furnished. Furnishing this information is optional.

7A. PURCHASER: *If you do not wish to complete Items 7B and 7C, please initial here* ▶ INITIALS

8A. SPOUSE: *If you do not wish to complete Items 8B and 8C, please initial here* ▶ INITIALS

7B. RACE/NATIONAL ORIGIN
☐ AMERICAN INDIAN ALASKAN NATIVE ☐ ASIAN PACIFIC ISLANDER ☐ BLACK
☐ HISPANIC ☐ WHITE ☐ OTHER *(Specify)*

7C. SEX
☐ FEMALE
☐ MALE

8B. RACE/NATIONAL ORIGIN
☐ AMERICAN INDIAN ALASKAN NATIVE ☐ ASIAN PACIFIC ISLANDER ☐ BLACK
☐ HISPANIC ☐ WHITE ☐ OTHER *(Specify)*

8C. SEX
☐ FEMALE
☐ MALE

9. PLEASE CHECK THE APPROPRIATE BOX(ES). IF ONE OR MORE ARE CHECKED, THIS CREDIT STATEMENT MUST INCLUDE INFORMATION CONCERNING THE PURCHASER'S SPOUSE (OR FORMER SPOUSE IF BOX "D" IS CHECKED). IF NO BOXES ARE CHECKED, NO INFORMATION CONCERNING THE SPOUSE NEED BE FURNISHED.

☐ A. THE SPOUSE WILL BE JOINTLY OBLIGATED WITH THE PURCHASER ON THE LOAN

☐ B. THE PURCHASER IS RELYING ON THE SPOUSE'S INCOME AS A BASIS FOR REPAYMENT OF THE LOAN

☐ C. THE PURCHASER IS MARRIED AND THE PROPERTY SECURING THE LOAN IS IN A COMMUNITY PROPERTY STATE

☐ D. THE PURCHASER IS RELYING ON ALIMONY, CHILD SUPPORT OR SEPARATE MAINTENANCE PAYMENTS FROM A SPOUSE OR FORMER SPOUSE AS A BASIS FOR REPAYMENT OF THE LOAN

10A. NAME AND ADDRESS OF NEXT OF KIN *(Include ZIP Code)*

10B. TELEPHONE NO. OF NEXT OF KIN *(Include Area Code)*

11. EMPLOYMENT RECORD OF PURCHASER *(Last 2 years. If additional space is needed, continue in Item 31.)*

NAME AND ADDRESS OF EMPLOYER	TITLE OF POSITION	DATE FROM	DATE TO	ANNUAL INCOME
A				$
B				$
C				$

12. EMPLOYMENT RECORD OF SPOUSE *(Last 2 years. If additional space is needed, continue in Item 31.)*

A				$
B				$
C				$

13. BUSINESS REFERENCES *(Give two)*
A
B

14. BANK ACCOUNTS *(If additional space is needed, continue in Item 31.)*
A
B

15A. NAME AND ADDRESS OF PRESENT LANDLORD OR AGENT

15B. PRESENT RENT
$ PER MONTH

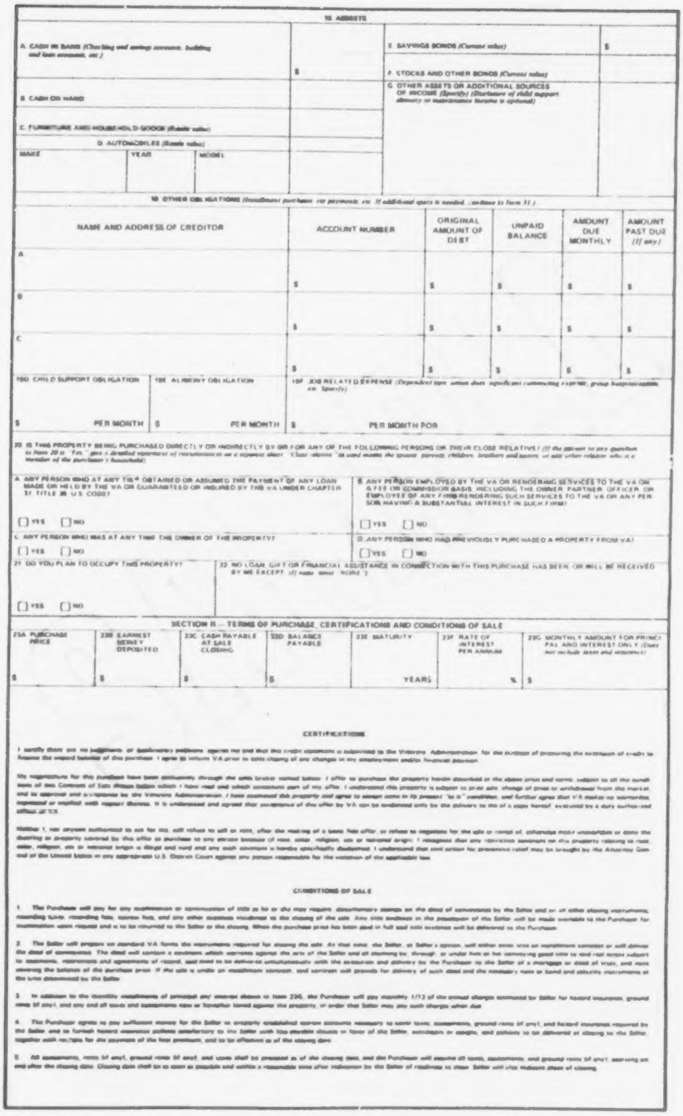
16. LENGTH OF TIME AT PRESENT ADDRESS
YEARS MONTHS

17. REAL ESTATE

17A. LOCATION AND TYPE OF REAL ESTATE OWNED	17B. VALUE OF PROPERTY	17C. NAME AND ADDRESS OF MORTGAGEE	17D. UNPAID BALANCE	17E. MONTHLY PAYMENT

VA FORM
OCT 1981 **26-6705**

EXISTING STOCKS OF VA FORM 26-6705, DEC 1976,
WILL BE USED.



18 ASSETS

A. CASH IN BANK *(Checking and savings accounts, building and loan accounts, etc.)*	$	E. SAVINGS BONDS *(Current value)*	$
		F. STOCKS AND OTHER BONDS *(Current value)*	
B. CASH ON HAND		G. OTHER ASSETS OR ADDITIONAL SOURCES OF INCOME *(Specify) (Disclosure of child support, alimony or maintenance income is optional)*	
C. FURNITURE AND HOUSEHOLD GOODS *(Resale value)*			
D. AUTOMOBILES *(Resale value)*			
MAKE / YEAR / MODEL			

19 OTHER OBLIGATIONS *(Installment purchases, car payments, etc. If additional space is needed, continue in Item 11.)*

NAME AND ADDRESS OF CREDITOR	ACCOUNT NUMBER	ORIGINAL AMOUNT OF DEBT	UNPAID BALANCE	AMOUNT DUE MONTHLY	AMOUNT PAST DUE *(If any)*
A	$	$	$	$	$
B	$	$	$	$	$
C	$	$	$	$	$

19D. CHILD SUPPORT OBLIGATION	19E. ALIMONY OBLIGATION	19F. JOB RELATED EXPENSE *(Dependent care, union dues, significant commuting expense, group hospitalization, etc. Specify)*
$ PER MONTH	$ PER MONTH	$ PER MONTH FOR

20 IS THIS PROPERTY BEING PURCHASED DIRECTLY OR INDIRECTLY BY OR FOR ANY OF THE FOLLOWING PERSONS OR THEIR CLOSE RELATIVE? *(If the answer to any question in Item 20 is "Yes," give a detailed statement of circumstances on a separate sheet. "Close relative" as used means the spouse, parents, children, brothers and sisters, or any other relative who is a member of the purchaser's household)*

A. ANY PERSON WHO AT ANY TIME OBTAINED OR ASSUMED THE PAYMENT OF ANY LOAN MADE OR HELD BY THE VA OR GUARANTEED OR INSURED BY THE VA UNDER CHAPTER 37, TITLE 38, U.S. CODE?

☐ YES ☐ NO

B. ANY PERSON EMPLOYED BY THE VA OR RENDERING SERVICES TO THE VA ON A FEE OR COMMISSION BASIS, INCLUDING THE OWNER, PARTNER, OFFICER, OR EMPLOYEE OF ANY FIRM RENDERING SUCH SERVICES TO THE VA OR ANY PERSON HAVING A SUBSTANTIAL INTEREST IN SUCH FIRM?

☐ YES ☐ NO

C. ANY PERSON WHO WAS AT ANY TIME THE OWNER OF THE PROPERTY?

☐ YES ☐ NO

D. ANY PERSON WHO HAD PREVIOUSLY PURCHASED A PROPERTY FROM VA?

☐ YES ☐ NO

21 DO YOU PLAN TO OCCUPY THIS PROPERTY?

☐ YES ☐ NO

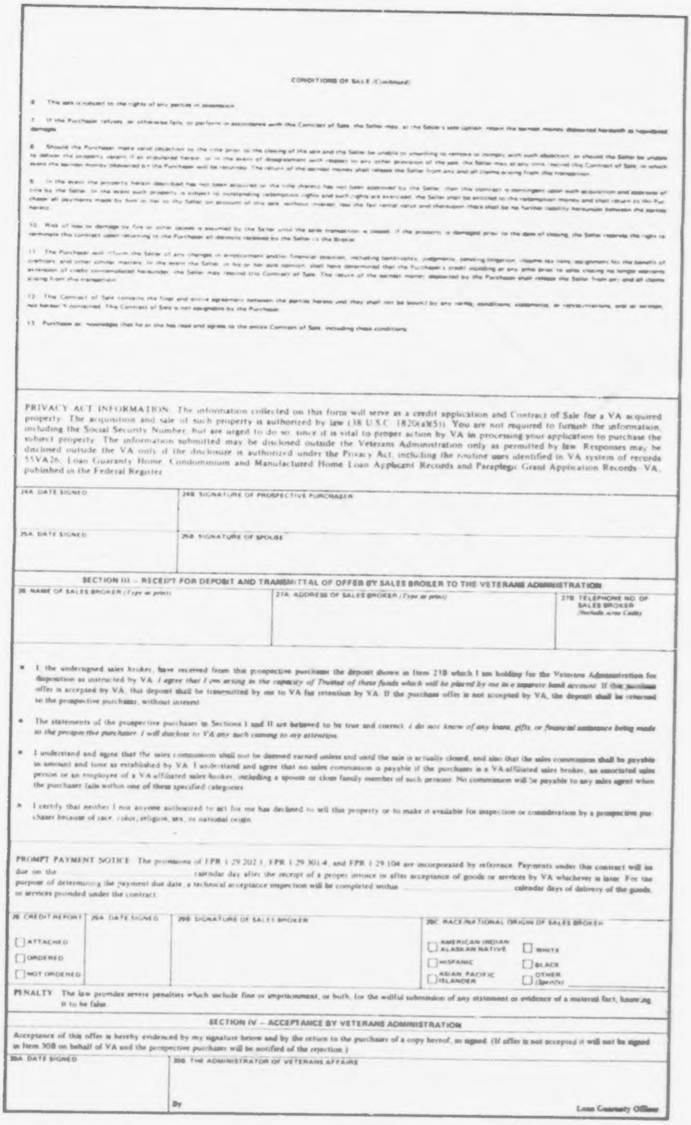
22 NO LOAN, GIFT OR FINANCIAL ASSISTANCE IN CONNECTION WITH THIS PURCHASE HAS BEEN, OR WILL BE RECEIVED BY ME EXCEPT *(If none, enter "NONE.")*

SECTION II – TERMS OF PURCHASE, CERTIFICATIONS AND CONDITIONS OF SALE

23A. PURCHASE PRICE	23B. EARNEST MONEY DEPOSITED	23C. CASH PAYABLE AT SALE CLOSING	23D. BALANCE PAYABLE	23E. MATURITY	23F. RATE OF INTEREST PER ANNUM	23G. MONTHLY AMOUNT FOR PRINCIPAL AND INTEREST ONLY *(Does not include taxes and insurance)*
$	$	$	$	YEARS	%	$

CERTIFICATIONS

CONDITIONS OF SALE



CONDITIONS OF SALE *(Continued)*

6. This sale is subject to the rights of any parties in possession.

7. If the Purchaser refuses, or otherwise fails, to perform in accordance with this Contract of Sale, the Seller may, at the Seller's sole option, retain the earnest money deposited herewith as liquidated damages.

8. Should the Purchaser make valid objection to the title prior to the closing of the sale and the Seller be unable or unwilling to remove or comply with such objection, or should the Seller be unable to deliver the property vacant if so stipulated herein, or in the event of disagreement with respect to any other provision of the sale, the Seller may at any time, rescind this Contract of Sale; in which event the earnest money deposited by the Purchaser will be returned. The return of the earnest money shall release the Seller from any and all claims arising from this transaction.

9. In the event the property herein described has not been acquired or the title thereto has not been approved by the Seller, then this contract is contingent upon such acquisition and approval of title by the Seller. In the event such property is subject to outstanding redemption rights and such rights are exercised, the Seller shall be entitled to the redemption money and shall return to the Purchaser all payments made by him or her to the Seller on account of this sale, without interest, less the fair rental value and thereupon there shall be no further liability hereunder between the parties hereto.

10. Risk of loss or damage by fire or other causes is assumed by the Seller until the sale transaction is closed. If the property is damaged prior to the date of closing, the Seller reserves the right to terminate this contract upon returning to the Purchaser all deposits received by the Seller or the Broker.

11. The Purchaser will inform the Seller of any changes in employment and/or financial position, including bankruptcy, judgments, pending litigation, income tax liens, assignment for the benefit of creditors, and other similar matters. In the event the Seller, in his or her sole opinion, shall have determined that the Purchaser's credit standing at any time prior to sales closing no longer warrants extension of credit contemplated hereunder, the Seller may rescind this Contract of Sale. The return of the earnest money deposited by the Purchaser shall release the Seller from any and all claims arising from this transaction.

12. This Contract of Sale contains the final and entire agreement between the parties hereto and they shall not be bound by any terms, conditions, statements, or representations, oral or written, not herein contained. This Contract of Sale is not assignable by the Purchaser.

13. Purchaser acknowledges that he or she has read and agrees to the entire Contract of Sale, including these conditions.

PRIVACY ACT INFORMATION: The information collected on this form will serve as a credit application and Contract of Sale for a VA acquired property. The acquisition and sale of such property is authorized by law (38 U.S.C. 1820(a)(5)). You are not required to furnish the information, including the Social Security Number, but are urged to do so, since it is vital to proper action by VA in processing your application to purchase the subject property. The information submitted may be disclosed outside the Veterans Administration only as permitted by law. Responses may be disclosed outside the VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in VA system of records 55VA26, Loan Guaranty Home, Condominium and Manufactured Home Loan Applicant Records and Paraplegic Grant Application Records—VA, published in the Federal Register.

24A. DATE SIGNED	24B. SIGNATURE OF PROSPECTIVE PURCHASER
25A. DATE SIGNED	25B. SIGNATURE OF SPOUSE

SECTION III – RECEIPT FOR DEPOSIT AND TRANSMITTAL OF OFFER BY SALES BROKER TO THE VETERANS ADMINISTRATION

26. NAME OF SALES BROKER *(Type or print)*	27A. ADDRESS OF SALES BROKER *(Type or print)*	27B. TELEPHONE NO. OF SALES BROKER *(Include area Code)*

- I, the undersigned sales broker, have received from this prospective purchaser the deposit shown in Item 21B which I am holding for the Veterans Administration for disposition as instructed by VA. *I agree that I am acting in the capacity of Trustee of these funds which will be placed by me in a separate bank account.* If this purchase offer is accepted by VA, this deposit shall be transmitted by me to VA for retention by VA. If the purchase offer is not accepted by VA, the deposit shall be returned to the prospective purchaser, without interest.
- The statements of the prospective purchaser in Sections I and II are believed to be true and correct. *I do not know of any loans, gifts, or financial assistance being made to the prospective purchaser. I will disclose to VA any such coming to my attention.*
- I understand and agree that the sales commission shall not be deemed earned unless and until the sale is actually closed, and also that the sales commission shall be payable in amount and time as established by VA. I understand and agree that no sales commission is payable if the purchaser is a VA-affiliated sales broker, an associated sales person or an employee of a VA-affiliated sales broker, including a spouse or close family member of such persons. No commission will be payable to any sales agent when the purchaser falls within one of these specified categories.
- I certify that neither I nor anyone authorized to act for me has declined to sell this property or to make it available for inspection or consideration by a prospective purchaser because of race, color, religion, sex, or national origin.

PROMPT PAYMENT NOTICE: The provisions of FPR 1-29.202-1, FPR 1-29.301-4, and FPR 1-29.104 are incorporated by reference. Payments under this contract will be due on the ______________ calendar day after the receipt of a proper invoice or after acceptance of goods or services by VA whichever is later. For the purpose of determining the payment due date, a technical acceptance inspection will be completed within ______________ calendar days of delivery of the goods or services provided under the contract.

28. CREDIT REPORT ☐ ATTACHED ☐ ORDERED ☐ NOT ORDERED	29A. DATE SIGNED	29B. SIGNATURE OF SALES BROKER	29C. RACE/NATIONAL ORIGIN OF SALES BROKER ☐ AMERICAN INDIAN ALASKAN NATIVE ☐ WHITE ☐ HISPANIC ☐ BLACK ☐ ASIAN PACIFIC ISLANDER ☐ OTHER *(Specify)* ______

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

SECTION IV – ACCEPTANCE BY VETERANS ADMINISTRATION

Acceptance of this offer is hereby evidenced by my signature below and by the return to the purchaser of a copy hereof, so signed. (If offer is not accepted it will not be signed in Item 30B on behalf of VA and the prospective purchaser will be notified of the rejection.)

30A. DATE SIGNED	30B. THE ADMINISTRATOR OF VETERANS AFFAIRS By ______ Loan Guaranty Officer

VA Form 26-6461a October 1967
Section 1820, Title 38, U.S.C.

TEXAS

STATE OF TEXAS,

County of

KNOW ALL MEN BY THESE PRESENTS that the Administrator of Veterans' Affairs, an Officer of the United States of America, whose address is Veterans Administration, Washington, D.C. 20420, hereinafter called Grantor for and in consideration of the sum of ten dollars ($10.00) and other valuable consideration

to him paid, and secured to be paid, by

hereinafter called Grantee(s), as follows:

SAMPLE

has granted, sold, and conveyed, and by these presents does grant, sell, and convey unto the said Grantee(s) of

the County of ______________________, State of ______________________,

all that certain tract or parcel of land in the County of ______________________, Texas, described as follows, to wit:

TO HAVE AND TO HOLD the above-described premises, together with all and singular, the rights and appurtenances thereto in anywise belonging unto the said Grantee(s) and Grantee's successors or heirs and assigns forever, and Grantor does hereby bind himself and his successors to warrant and forever defend all and singular the said premises unto the said Grantee(s) and Grantee's successors or assigns, against every person whomsoever lawfully claiming, or to claim the same or any part thereof, by, through, or under Grantor.

"But it is expressly agreed and stipulated that the Vendor's Lien is retained against the above-described property, premises, and improvements, until the above-described note and all interest thereon are fully paid according to face and tenor, effect and reading, when this deed shall become absolute."

IN WITNESS WHEREOF, Grantor, on the day of A.D. 19 , has caused this instrument to be signed and sealed in his name and on his behalf by the undersigned Loan Guaranty Officer, being thereunto duly appointed, qualified, and acting pursuant to sections 212 and 1820 of Title 38, United States Code, and sections 36:4342 and 36:4520 of the regulations pursuant thereto as amended, and who is authorized to execute this instrument.

*

As Administrator of Veterans' Affairs.

*By

Loan Guaranty Officer

Authorization recorded in volume of the records of the County in which the above-described property is situated at page

THE STATE OF TEXAS,
County of

BEFORE ME, the undersigned authority on this day personally appeared , known to me to be the person whose name is subscribed to the foregoing instrument, who, being by me duly sworn, did say that he is a Loan Guaranty Officer of the Veterans Administration, an agency of the United States Government, and is duly authorized to execute this deed on behalf of the Grantor, the Administrator of Veterans' Affairs named, and acknowledged to me that he subscribed the name of said Administrator thereto and that he executed such instrument on behalf of said Administrator for the purposes and consideration therein expressed, and in the capacity stated.

GIVEN UNDER MY HAND AND SEAL OF OFFICE THIS THE day of , A.D. 19

*

[L.S.]

Notary Public in and for—
County, Texas

Note 1. [illegible] consideration is paid.
*Note 2. [illegible] of Administrator of Veterans Affairs and Loan Guaranty Officer, also names of Notary Public immediately underneath each signature.

CLERK'S CERTIFICATE

THE STATE OF TEXAS, |
County of | ss:

I, , County Clerk of the County Court of said County, do hereby certify that the foregoing instrument of writing dated on the day of , A.D. 19 , with its Certificate of Authentication, was filed for record in my office on the day of , A.D. 19 , at o'clock M., and duly recorded this day of , A.D. 19 , at o'clock M., in the records of said County, in volume , on pages

WITNESS MY HAND AND SEAL OF THE COUNTY COURT of said County, at office in , the day and year last above written.

[L.S.]

County Clerk County, Texas.
By , Deputy.

No.

WARRANTY DEED

With Vendor's Lien

FROM

ADMINISTRATOR OF VETERANS' AFFAIRS

TO

FILED FOR RECORD

This day of

A.D. 19 , at o'clock M.

County Clerk,

County, Texas

By , *Deputy*

RECORDED

A.D. 19

in county records.

Book , page

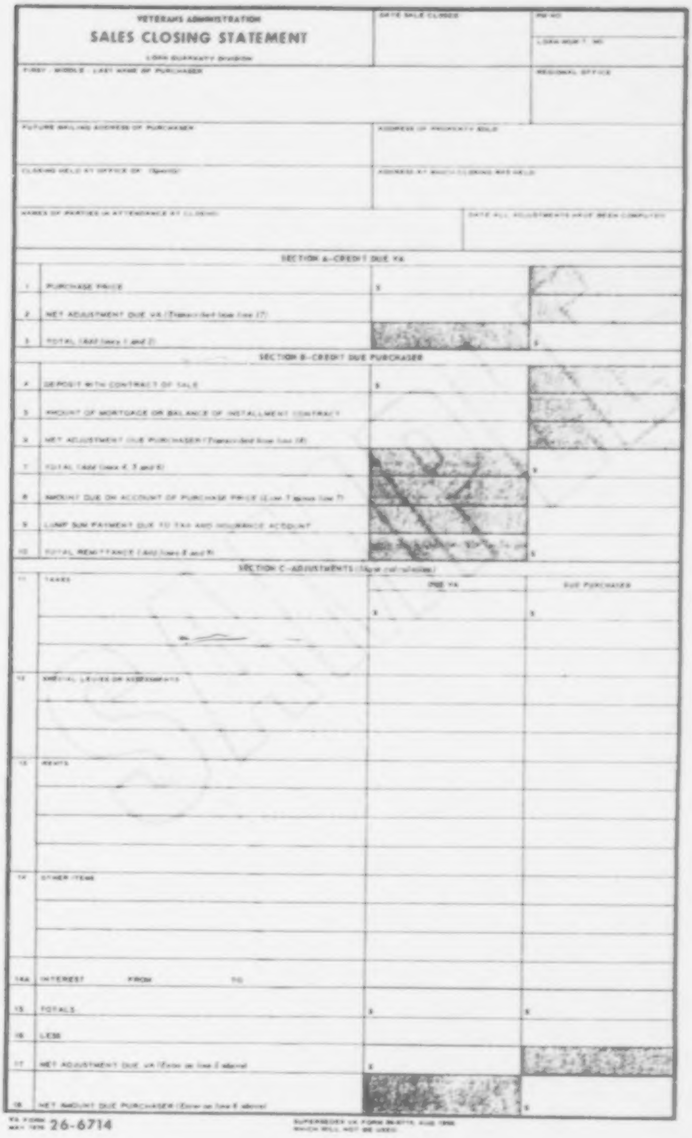
County Clerk

Deputy

Recording fee, $

This instrument should be filed immediately with the County Clerk for record.

[illegible]



VETERANS ADMINISTRATION

SALES CLOSING STATEMENT

LOAN GUARANTY DIVISION

	DATE SALE CLOSED	RM NO. LOAN ACCT. NO.
FIRST - MIDDLE - LAST NAME OF PURCHASER		REGIONAL OFFICE
FUTURE MAILING ADDRESS OF PURCHASER	ADDRESS OF PROPERTY SOLD	
CLOSING HELD AT OFFICE OF: (Specify)	ADDRESS AT WHICH CLOSING WAS HELD	
NAMES OF PARTIES IN ATTENDANCE AT CLOSING	DATE ALL ADJUSTMENTS HAVE BEEN COMPUTED	

SECTION A—CREDIT DUE VA

1	PURCHASE PRICE	$	
2	NET ADJUSTMENT DUE VA (Transcribed from line 17)		
3	TOTAL (Add lines 1 and 2)		$

SECTION B—CREDIT DUE PURCHASER

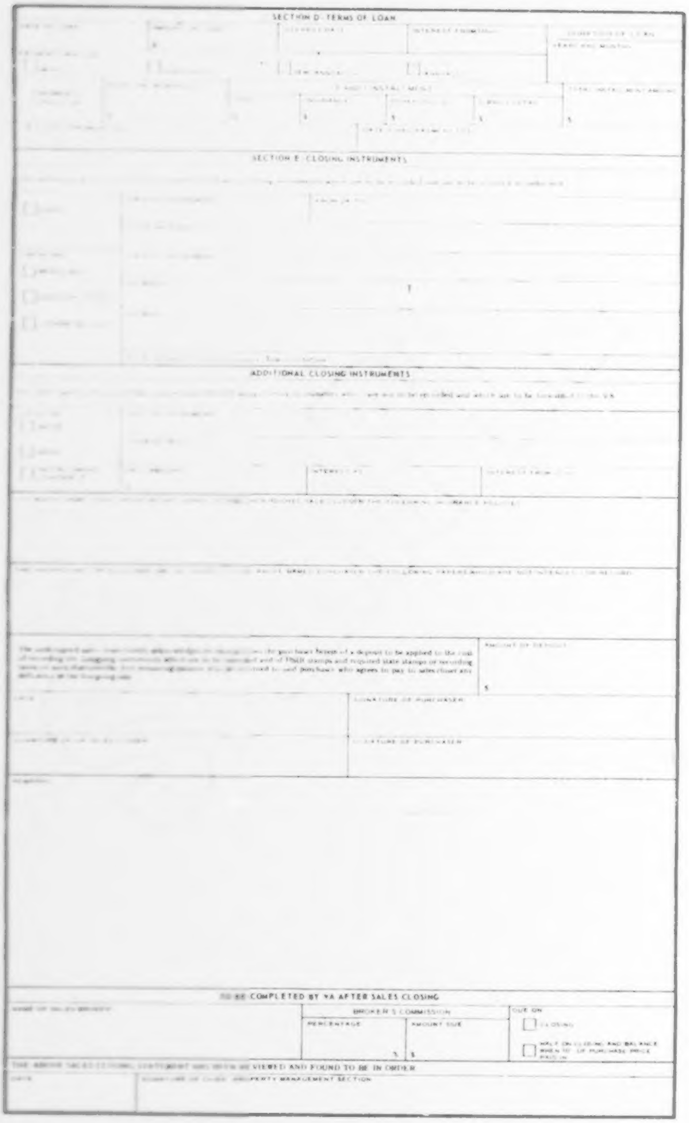
4	DEPOSIT WITH CONTRACT OF SALE	$	
5	AMOUNT OF MORTGAGE OR BALANCE OF INSTALLMENT CONTRACT		
6	NET ADJUSTMENT DUE PURCHASER (Transcribed from line 18)		
7	TOTAL (Add lines 4, 5 and 6)		$
8	AMOUNT DUE ON ACCOUNT OF PURCHASE PRICE (Line 3 minus line 7)		
9	LUMP SUM PAYMENT DUE TO TAX AND INSURANCE ACCOUNT		
10	TOTAL REMITTANCE (Add lines 8 and 9)		$

SECTION C—ADJUSTMENTS (Show calculations)

		DUE VA	DUE PURCHASER
11	TAXES	$	$
12	SPECIAL LEVIES OR ASSESSMENTS		
13	RENTS		
14	OTHER ITEMS		
14A	INTEREST FROM TO		
15	TOTALS	$	$
16	LESS		
17	NET ADJUSTMENT DUE VA (Enter on line 2 above)	$	
18	NET AMOUNT DUE PURCHASER (Enter on line 6 above)		$

VA FORM MAY 1970 26-6714

SUPERSEDES VA FORM 26-6714, AUG 1966, WHICH WILL NOT BE USED.



SECTION D - TERMS OF LOAN

INTEREST FROM

DURATION OF LOAN

YEARS AND MONTHS

TOTAL INSTALLMENT AMOUNT

SECTION E - CLOSING INSTRUMENTS

ADDITIONAL CLOSING INSTRUMENTS

INTEREST AT

INTEREST FROM

AMOUNT OF DEPOSIT

$

SIGNATURE OF PURCHASER

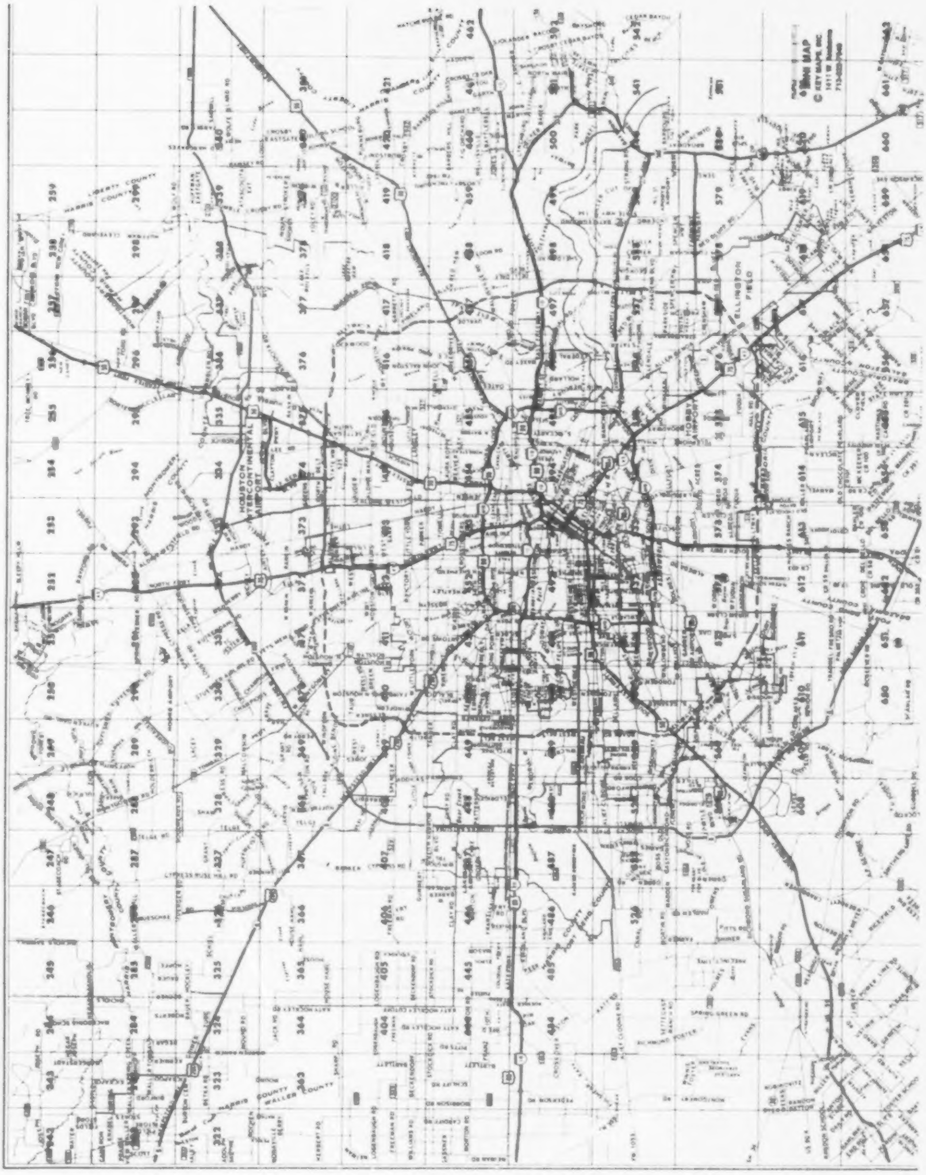
SIGNATURE OF PURCHASER

TO BE COMPLETED BY VA AFTER SALES CLOSING

	BROKER'S COMMISSION		DUE ON
NAME OF SALES BROKER	PERCENTAGE	AMOUNT DUE	☐ CLOSING ☐ HALF ON CLOSING AND BALANCE WHEN OF PURCHASE PRICE PAID IN
	%	$	

THE ABOVE SALES CLOSING STATEMENT HAS BEEN REVIEWED AND FOUND TO BE IN ORDER

DATE	SIGNATURE OF CHIEF, PROPERTY MANAGEMENT SECTION


HOUSTON INTERCONTINENTAL AIRPORT
ELLINGTON FIELD
HOBBY
LIBERTY COUNTY
HARRIS COUNTY
WALLER COUNTY
KEY MAPS INC

LISTING OF HOUSES TO BE SOLD JUNE 7, 1985
Doors Open at 5:00 p.m. — Auction at 7:00 p.m.

HOUSE NO.	ADDRESS	CITY	ZIP	LOT SIZE	RM	BR	BA	GAR.	FND.	CASE NUMBER
1	29622 Atherstone	Spring	77373	60x110	7	4	2½	2AG	S	25194
2	3607 Balmorhea	Houston	77039	65x110	6	3	2	2AG	S	478142
3	25022 Barmby Dr.	Tomball	77375	65x115	8	3	2½	2AG	S	517330
4	23835 Beaverwood	Spring	77373	60x110	6	3	2½	2AG	S	515064
5	11726 Boxhill Dr.	Houston	77066	55x105	6	3	2	2AG	S	541744
6	3411 Bristlecone Trail	Spring	77380	70x150	6	3	2	2AG	S	521324
7	12215 Carola Forrest	Houston	77044	54x120	6	3	2	2AG	S	491830
8	13519 Castilian	Houston	77015	19x72	6	4	2	2CP	S	497661
9	9133 Chatwood	Houston	77078	70x120	7	3	1	1DG	S	432009
10	5729 Collins Ave.	Houston	77016	100x150	7	4	2	2CP	SP	21368
11	3315 Creek Grove	Houston	77039	65x105	6	3	2	2AG	S	25978
12	9510 Crestview	Houston	77078	60x129	6	3	1	0	S	496357
13	12402 Currin Forest Dr.	Houston	77066	68x109	6	3	2	2AG	S	496374
14	5635 DeSoto Dr. 1038-10	Houston	77091	N/A	5	3	2	1CP	N/A	520363
15	5675 DeSoto #137	Houston	77091	N/A	4	1	1	1CP	N/A	495136
16	5675 DeSota 229-2	Houston	77091	N/A	4	2	1	1CP	N/A	515417
17	5685 DeSota 129A	Houston	77091	N/A	4	2	1	1CP	N/A	516727
18	104 Dogwood	Porter	77365	90x200	6	4	2	0	S	26022
19	12031 Drummond Pk.	Houston	77044	55x125	5	3	2½	2AG	S	498446
20	1715 Evesham Dr.	Houston	77015	Irr.	6	3	2½	2AG	S	492315
21	3401 Exchange	Houston	77020	50x135	6	3	1	0	P	548785
22	8652 Flower Path	Houston	77044	44x120	4	2	1	1AG	S	517603
23	6102 Grey Oaks	Houston	77050	70x120	7	3	3	2DG	2	26214
24	6822 Henley	Houston	77016	55x110	4	2	1	0	S	26370
25	12246 Haroldson Forest	Houston	77044	65x115	6	3	2	2AG	S	453653
26	7202 Haverton	Houston	77016	58x110	6	3	1½	2AG	S	26705
27	7102 Hedgewood	Houston	77016	Irr.	6	3	1½	2AG	S	492643
28	15231 Heron Pk. Dr.	Humble	77338	65x115	8	4	2	2AG	S	568306
29	310 Hickory Ridge	Spring	77373	80x100	7	4	2½	2AG	S	523534
30	4434 Hirshfield Rd.	Spring	77373	65x120	6	3	2	2AG	S	522918
31	3455 Hombley Rd.	Houston	77066	Irr.	7	3	2½	2AG	S	538957
32	6541 Huffman Cleveland	Huffman	77336	100x120	6	3	1	0	D	428242
33	10922 Indian Vista	Houston	77064	45x106	6	3	2	2CP	S	499960
34	7934 Joy	Houston	77028	50x100	5	3	1	0	P	522806
35	8837 Kentshire	Houston	77078	60x120	6	3	1½	1DG	P	27444
36	9407 Kilkenny	Spring	77379	40x125	6	3	2	2AG	S	430027
37	1726 Lakeshore	Humble	77338	Irr.	6	3	1½	2AG	S	538213
38	3201 Lakewood	Houston	77093	60x100	7	3	1	0	S	26383
39	4410 Langley	Houston	77016	50x247	5	2	1	0	P	21950
40	8969 Las Cruces Dr.	Houston	77078	Irr.	5	3	1	1CP	S	450021
41	11139 Ledford Ln.	Houston	77016	67x170	7	3	2	2AG	S	474843
42	2502 Leichester	Spring	77373	75x131	6	3	2	2AG	S	427541
43	3230 Lucida Ln.	Spring	77373	60x120	5	2	1½	1AG	S	550656
44	14122 Magnolia Springs	Houston	77066	Irr.	6	3	2	2AG	S	503025
45	494 W. Magnolia	New Caney	77357	3/4 Ac.	7	3	2	2DG	S	475736
46	2335 Marble Falls Drive	Spring	77373	65x115	5	3	2	2AG	S	433053
47	3811 Mattingham Drive	Houston	77066	55x105	6	3	2	2AG	S	552943
48	29507 Memorial Dr.	Spring	77373	65x100	9	4	2	2AG	S	389839
49	13134 Nature Trail	Houston	77044	47x110	5	3	2	1AG	S	537121
50	6215 Northpost	Houston	77049	60x115	5	3	2	2AG	S	433203
51	9006 Oak Knoll	Houston	77028	60x120	6	3	1	2CP	S	521197
52	3630 Oakhall Dr.	Houston	77066	60x105	4	2	2	2AG	S	515732
53	3310 Otterbury	Houston	77039	60x110	7	3	1½	0	S	27014
54	416 Pecore	Houston	77009	50x100	7	3	2	2DG	P	460134
55	10910 Penelope	Houston	77013	130x178	5	2	1	2DG	P	26426
56	2422 Piddler Dr.	Spring	77373	62x105	7	4	2	2AG	S	494160
57	7103 Pinehook Ln.	Houston	77016	60x110	6	3	2	2AG	S	26479
58	206 Plaza Verde Dr. D-11	Houston	77038	N/A	5	2	2	1CP		493378
59	29502 Raestone	Spring	77386	75x100	6	3	2	2AG	S	385938
60	14414 Ravendale	Humble	77338	60x140	7	3	2	2DG	S	26492
61	9911 Rippling Fields	Houston	77040	Irr.	8	4	2	2AG	S	459886
62	17750 Riverside	Houston	77044	100x100	4	2	1	2DG	P	436200
63	10221 Rockaway	Houston	77016	60x110	6	2	1	1CP	S	25393
64	Rt. 1, Box 405X	New Caney	77357	100x150	7	3	1	0	S	430277
65	Rt. 1, Box 420-H	New Caney	77355	180x168	5	2	1	0	P	409315
66	Rt. 2, Box 268	New Caney	77357	Irr.	7	3	1½	1AG	S	521068
67	Rt. 4, Box 1380	New Caney	77357	1.3 A	9	3	2	2DG	S	536451
68	6511 Sandy Oaks	Houston	77050	60x110	5	3	1½	1AG	S	26847

LISTING OF HOUSES TO BE SOLD JUNE 7, 1985
Doors Open at 5:00 p.m. — Auction at 7:00 p.m.

HOUSE NO.	ADDRESS	CITY	ZIP	LOT SZ.	RMS.	BDR.	BATH	GAR.	FND.	CASE NUMBER
69	14835 Shottery Dr.	Houston	77015	Irr.	6	4	2	2AG	S	590381
70	7819 Smokey Wood	Houston	77086	60x105	6	3	2	2AG	S	26146
71	106 Sparkling Water	Huffman	77336	Irr.	6	3	2	2DG	S	457379
72	11151 Spottswood Drive	Houston	77016	60x120	6	3	1	1AG	S	26605
73	23222 Summer Pine Drive	Spring	77373	42x133	4	1	1	1AG	S	570886
74	4631 Tealgate	Spring	77373	65x120	6	3	2	2AG	S	570769
75	4623 Tealgate Dr.	Spring	77373	65x120	6	4	2	2AG	S	548718
76	4018 Trent Rd.	Huffman	77336	233x297	5	2	1	0	S	488018
77	9927 Valley Mill Ct.	Houston	77078	Irr.	5	3	2	2AG	S	475834
78	5002 Van Zandt	Houston	77093	120x150	6	3	2	2DG	P	25499
79	3319 Walhalla Dr.	Houston	77066	60x105	7	4	2	2AG	S	541258
80	7942 Way	Houston	77028	73x130	6	2	1	0	S	522235
81	7117 Weyburn	Houston	77028	60x120	6	3	1	1DG	P	458639
82	7746 Whidby Island	Houston	77086	60x140	6	3	1	2AG	P	434607
83	10903 Wilkenberg Drive	Houston	77086	64x110	6	3	2	2AG	S	520799
84	2719 Winter Pk. Ct.	Houston	77067	60x110	7	3	2	2AG	S	551842
85	1118 Wisterwood Drive	Houston	77043	Irr.	6	3	2	2AG	S	472323
86	1438-D Woodlane Road	Splendora	77372	150x300	6	2	1½	0	S	497684
87	114 Yupon	Porter	77365	100x250	7	4	2	2AG	S	26517

LISTING OF HOUSES TO BE SOLD JUNE 8, 1985
Doors Open at 9:00 a.m. — Auction at 10:00 a.m.

HOUSE NO.	ADDRESS	CITY	ZIP	LOT SZ.	RMS.	BDR.	BATH	GAR.	FND.	CASE NUMBER
88	1216 8th Ave. N.	Texas City	77590	Irr.	5	2	1	1G1CP	P	490587
89	1911 36th Ave. N.	Texas City	77590	50x196	5	2	1	0	S	26478
90	13302 Barranca Dr.	Houston	77083	45x115	4	2	1	0	S	499661
91	9327 Barrowhollow	Houston	77083	45x110	6	3	2	0	S	27582
92	2824 S. Bartell, 1	Houston	77054	N/A	3	1	1	1CP		500330
93	2830 S. Bartell, 11	Houston	77054	N/A	4	2	1	1CP		586954
94	2832 S. Bartell, 32-D	Houston	77054	N/A	3	1	1	1CP		553107
95	2814 S. Bartell, 35-10	Houston	77074	N/A	4	2	1	1CP		521145
96	13327 Bassford Dr.	Houston	77083	45x115	5	2	1	0	S	508830
97	6715 W. Bayou Dr.	Hitchcock	77563	100x100	6	3	2	2AG	S	523214
98	6107 Belarbor	Houston	77033	56x110	6	3	1	1AG	S	24088
99	5819 Belcrest	Houston	77033	60x120	6	3	1	1AG	S	456685
100	6123 Belcrest	Houston	77033	Irr.	7	3	1	0	S	515925
101	708 E. Belmont	Pasadena	77506	60x110	5	3	1	1DG	S	26106
102	12400 Brookglade Cir. - 69	Houston	77099	20x67	5	2	2½	2DG	S	515463
103	12300 Brookglade Cir. - 79	Houston	77099	20x90	5	2	2½	2DG	S	524655
104	12300 Brookglade Cir. - 113	Houston	77099	20x60	5	2	2½	2DG	S	524876
105	254 Brookwood	Channelvw.	77530	54x120	6	3	1½	1AG	S	479308
106	5306 Burma	Houston	77033	50x120	6	3	1	1AG	S	27478
107	5414 Chennault	Houston	77033	50x110	4	2	1	1G1CP	S	481684
108	10501 Chickadee	Houston	77048	104x206	5	2	1	1DG	S	436740
109	14106 Country Manor Dr.	Sugarland	77021	70x130	6	3	1½	2CP	P	541918
110	11821 Dale	Galveston	77551	55x115	3	1	1	0	P	523353
111	7906 Darnay	Houston	77033	50x110	6	3	1	1CP	S	430706
112	5809 Dieppe	Houston	77033	50x110	4	2	1	1G1CP	S	16456
113	5906 Dieppe	Houston	77033	50x110	5	3	1	1AG	S	25492
114	815 Doncrest	Channelvw.	77530	55x120	9	5	2	0	S	431678
115	5309 Doolittle	Houston	77033	50x120	5	2	1	1CP	S	26801
116	5951 Doolittle	Houston	77033	63x114	5	2	1	1AG	S	516756
117	10759 Dulcimer	Houston	77051	Irr.	7	3	1	2CP	S	472663
118	16314 Espinosa	Houston	77083	55x110	6	3	2	2AG	S	492210
119	12123 Fawnway	Houston	77048	50x120	7	3	1½	0	S	23587
120	16914 Folsom Dr.	Houston	77049	Irr.	6	3	2	2AG	S	548848
121	13338 Force	Houston	77015	60x130	5	2	1	0	S	540054
122	10403 Forum Pk. 34-A	Houston	77036	N/A	5	2	2	1CP		495815

LISTING OF HOUSES TO BE SOLD JUNE 8, 1985
Doors Open at 9:00 a.m. — Auction at 10:00 a.m.

HOUSE NO.	ADDRESS	CITY	ZIP	LOT SZ.	RMS.	BDR.	BATH	GAR.	FND.	CASE NUMBER
123	6534 Glenrock	Houston	77087	100x120	7	3	2½	0	S	587177
124	7313 Gulf Frwy. 1109	Houston	77017	N/A	3	1	1	1CP		543381
125	7313 Gulf Frwy. 114-1	Houston	77017	N/A	3	1	1	1CP		514404
126	10339 Gulfstream Lane	Sugarland	77478	Irr.	5	2	2	2AG	S	500675
127	8435 Hearth Dr. S-11	Houston	77054	N/A	4	2	1	1CP		472409
128	4319 Hickok Ln.	Houston	77047	Irr.	7	3	1	2CP	S	26065
129	2307 Jackson	Lamarque	77568	30x100	4	2	1	1CP	P	495382
130	16246 Knollridge Ct.	Houston	77053	Irr.	6	3	2	2AG	S	27682
131	327 Land Grant	Richmond	77469	Irr.	7	3	2	2AG	S	521180
132	1821 Marilyn St.	Rosenberg	77471	75x120	6	3	2	0	S-P	537453
133	5634 Maywood Dr.	Houston	77053	60x138	8	4	2½	1AG	S	477071
134	13347 Mobile	Houston	77015	60x130	6	3	2	1CP	S	567362
135	1906 Mockingbird Ln.	LaPorte	77571	65x100	6	3	2	2AG	S	26197
136	308 Morningside	League Cty	77573	60x120	6	3	2	2AG	S	477495
937	407 Morningside	League Cty	77573	60x115	6	2	2½	2AG	S	481091
138	12714 Mosscrest	Houston	77048	60x100	6	3	1½	1AG	S	25583
139	1127 Niagra St.	Houston	77051	70x150	5	2	1	1AG	P	499911
140	5714 Northridge	Houston	77033	65x110	6	2	1	1AG	S	519504
141	2007 Oaks Dr.	Pasadena	77502	100x100	5	3	2	2AG	S	454102
142	5214 E. Orem	Houston	77054	60x110	7	3	2	2AG	S	26256
143	5526 Osprey	Houston	77048	60x112	5	3	2	1AG	S	472340
144	8158 Pansy	Houston	77033	Irr.	6	3	1½	2CP	S	406167
145	12807 Paney	Houston	77048	55x110	6	3	1½	1AG	S	26499
146	15123 Peachmeadow	Channelvw.	77530	60x105	6	3	2	2AG	S	523081
147	13009 Peoria	Houston	77015	60x140	7	3	1	2AG	S	430156
148	4842 Pershing	Houston	77033	55x110	8	4	2	1AG	S	26404
149	5030-5030½ Pershing	Houston	77033	55x120	7	3	2	0	S	517965
150	16506 Quail Run Dr.	Missouri C.	77489	62x110	7	4	2	2AG	S	26881
151	4907 Quebec Blvd.	Richmond	77469	59x110	5	3	2	2AG	S	520048
152	4905 E. Ridgecreek	Houston	77053	60x110	6	3	2	1AG	S	27446
153	4902 Ridge Creek Circle	Houston	77053	70x100	6	3	1½	1AG	S	26638
154	4810 Ridgeton	Houston	77087	60x110	7	3	2	2AG	S	493576
155	7419 Seminole	Baytown	77520	68x105	5	3	2	2AG	S	524317
156	5539 Shamrock	Houston	77017	60x100	6	3	1	0	S	26085
157	8138 Sharondale	Houston	77033	60x150	6	2	1½	2DG	S	26510
158	12465 Sharpview	Houston	77072	38x52	4	2	2	1CP	S	407231
159	5518 South Lea	Houston	77033	53x110	5	2	1	0	S	470969
160	5965 Southmont	Houston	77033	60x110	6	2	1	0	S	524426
161	506 Stonewall	Richmond	77469	60x105	6	3	1½	1AG	S	494719
162	607 Tara Plantation	Richmond	77469	60x105	6	3	2	2AG	S	565111
163	15003 Tippcrest Dr.	Channelvw.	77530	52x120	7	4	2	2AG	S	20151
164	12818 Townway Drive	Sugarland	77478	65x115	7	3	2	2AG	S	536904
165	4315 Trail Lake	Houston	77045	61x110	6	3	1	2AG	S	480957
166	3327 Trail Lake	Houston	77054	62x115	5	3	1	1AG	S	26908
167	10555 Turtlewood Ct. - 2412	Houston	77072	N/A	4	2	2	1CP		539713
168	10555 Turtlewood Ct. - 2502	Houston	77072	N/A	4	1	1	1CP		544589
169	10555 Turtlewood Ct. - 2508	Houston	77072	N/A	3	1	1	1CP		540206
170	10555 Turtlewood Ct. - 2909	Houston	77072	N/A	4	2	2	1CP		550605
171	6925 Van Etten	Houston	77021	70x130	6	3	1½	2CP	S	496080
172	6119 Westover	Houston	77033	Irr.	5	2	1	1AG	S	493273
173	907 Yaupon	Pasadena	77052	60x110	6	2	1	1AG	S	26575
174	15534 Zabolia 101-A	Webster	77598	N/A	5	2	2	1CP		554334
175	7107 Ziegiers Grove	Richmond	77469	60x110	6	3	2	2AG	S	537712

HOUSES TO BE SOLD JUNE 7, 1985

HOUSE NO. 1 - Key Map #293A

Address 22622 Atherstone Case #25194
City Spring Zip 77373 Lot Size 60x110
Rms 7 | Bdrms 4 | Baths 2½ | Gar 2AG

HOUSE NO. 2 - Key Map #414B

Address 3607 Balmorhea Case #478142
City Houston Zip 77039 Lot Size 65x110
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 3 - Key Map #250W

Address 25022 Barmby Dr Case #517330
City Tomball Zip 77375 Lot Size 65x115
Rms 8 | Bdrms 3 | Baths 2½ | Gar 2AG

HOUSE NO. 4 - Key Map #293T

Address 23835 Beaverwood Case #515064
City Spring Zip 77373 Lot Size 60x110
Rms 6 | Bdrms 3 | Baths 2½ | Gar 2AG

HOUSE NO. 5 - Key Map #371P

Address 11726 Boxhill Dr Case #541744
City Houston Zip 77066 Lot Size 55x105
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 6 - Key Map #251S

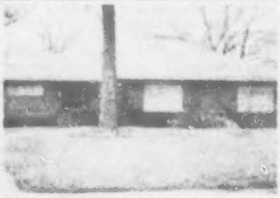
Address 3411 Bristlecone Trail Case #521324
City Spring Zip 77380 Lot Size 70x150
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 7 - Key Map #416C

Address 12215 Carola Forrest Case #491830
City Houston Zip 77044 Lot Size 54x120
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 8 - Key Map #457X

Address 13519 Castilian Case #497661
City Houston Zip 77015 Lot Size 19x72
Rms 6 | Bdrms 4 | Baths 2 | Gar 2CP



HOUSE NO. 9 - Key Map #455H

Address 9133 Chatwood Case #452009
City Houston Zip 77078 Lot Size 70x120
Rms 7 | Bdrms 3 | Baths 1 | Gar 1DG

HOUSE NO. 10 - Key Map #414R

Address 5729 Collins Ave Case #21362
City Houston Zip 77016 Lot Size 100x150
Rms 7 | Bdrms 4 | Baths 2 | Gar 2CP

HOUSE NO. 11 - Key Map #371U

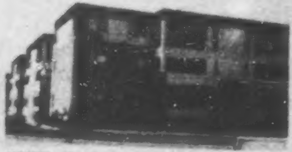
Address 3315 Creek Grove Case #25978
City Houston Zip 77039 Lot Size 65x105
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 12 - Key Map #455H

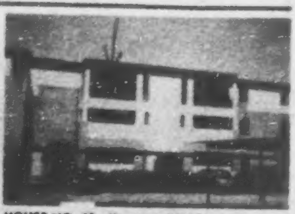
Address 9510 Crestview Case #496357
City Houston Zip 77078 Lot Size 60x129
Rms 6 | Bdrms 3 | Baths 1 | Gar 0

HOUSES TO BE SOLD JUNE 7, 1985

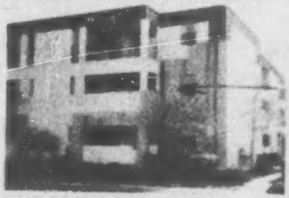
HOUSE NO. 13 - Key May #416L
Address 12402 Currin Forest Dr. Case #496374
City Houston Zip 77066 Lot Size 68x109
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG



HOUSE NO. 14 - Key Map #451C
Address 5635 DeSoto Dr 1038-10 Case #520363
City Houston Zip 77091 Lot Size N/A
Rms 5 | Bdrms 3 | Baths 2 | Gar 1CP



HOUSE NO. 15 - Key Map #451C
Address 5675 DeSoto #137 Case #495156
City Houston Zip 77091 Lot Size N/A
Rms 4 | Bdrms 1 | Baths 1 | Gar 1CP



HOUSE NO. 16 - Key Map #451C
Address 5675 DeSoto 299-2 Case #515417
City Houston Zip 77091 Lot Size N/A
Rms 4 | Bdrms 2 | Baths 1 | Gar 1CP

HOUSE NO. 17 - Key Map #451C
Address 5685 DeSoto, 129A Case #516727
City Houston Zip 77091 Lot Size N/A
Rms 4 | Bdrms 2 | Baths 1 | Gar 1CP

HOUSE NO. 18
Address 104 Dogwood Case #26092
City Porter Zip 77365 Lot Size 90x200
Rms 6 | Bdrms 4 | Baths 2 | Gar 0

HOUSE NO. 19 - Key Map #416G
Address 12031 Drummond Pt. Case #498446
City Houston Zip 77044 Lot Size 55x125
Rms 6 | Bdrms 3 | Baths 2½ | Gar 2AG

HOUSE NO. 20 - Key Map #457U
Address 1715 Evesham Dr. Case #499315
City Houston Zip 77015 Lot Size Irr
Rms 6 | Bdrms 3 | Baths 2½ | Gar 2AG

HOUSE NO. 21 - Key Map #455W
Address 3401 Exchange Case #548785
City Houston Zip 77020 Lot Size 50x135
Rms 6 | Bdrms 3 | Baths 1 | Gar 0

HOUSE NO. 22 - Key Map #457A
Address 8652 Flower Path Case #517683
City Houston Zip 77044 Lot Size 44x120
Rms 4 | Bdrms 2 | Baths 1 | Gar 1AG

HOUSE NO. 23 - Key Map #415E
Address 6102 Grey Oaks Case #26814
City Houston Zip 77050 Lot Size 70x120
Rms 7 | Bdrms 3 | Baths 3 | Gar 2DG

HOUSE NO. 24 - Key Map #415G
Address 6802 Henley Case #26370
City Houston Zip 77016 Lot Size 55x110
Rms 4 | Bdrms 2 | Baths 1 | Gar 0

HOUSES TO BE SOLD JUNE 7, 1985

HOUSE NO. 25 - Key Map #416R
Address: 12246 Haroldson Forest Case #453653
City: Houston Zip: 77044 Lot Size: 65x115
Rms: 6 Bdrms: 3 Baths: 2 Gar: 2AG

HOUSE NO. 26 - Key Map #415P
Address: 7202 Haverton Case #26705
City: Houston Zip: 77016 Lot Size: 58x110
Rms: 6 Bdrms: 3 Baths: 1½ Gar: 2AG

HOUSE NO. 27 - Key Map #415P
Address: 7102 Hedgewood Case #492663
City: Houston Zip: 77016 Lot Size: Irr
Rms: 6 Bdrms: 3 Baths: 1½ Gar: 2AG

HOUSE NO. 28 - Key Map #375Q
Address: 15231 Heron Pk. Dr. Case #568306
City: Humble Zip: 77338 Lot Size: 65x115
Rms: 8 Bdrms: 4 Baths: 2 Gar: 1AG

HOUSE NO. 29 - Key Map #252A
Address: 310 Hickory Ridge Case #523534
City: Spring Zip: 77373 Lot Size: 80x110
Rms: 7 Bdrms: 4 Baths: 2½ Gar: 2AG

HOUSE NO. 30 - Key Map #333C
Address: 4434 Hirshfield Rd. Case #522918
City: Spring Zip: 77373 Lot Size: 65x120
Rms: 6 Bdrms: 3 Baths: 2 Gar: 2AG

HOUSE NO. 31 - Key Map #371Q
Address: 3455 Hombley Rd. Case #538957
City: Houston Zip: 77066 Lot Size: Irr
Rms: 7 Bdrms: 3 Baths: 2½ Gar: 2AG

HOUSE NO. 32
Address: 6541 Huffman Cleveland Case #482242
City: Huffman Zip: 77336 Lot Size: 100x120
Rms: 6 Bdrms: 3 Baths: 1 Gar: 0

HOUSE NO. 33 - Key Map #396X
Address: 10922 Indian Vista Case #499960
City: Houston Zip: 77064 Lot Size: 45x106
Rms: 6 Bdrms: 3 Baths: 2 Gar: 2CP

HOUSE NO. 34 - Key Map #455K
Address: 7934 Joy Case #522806
City: Houston Zip: 77028 Lot Size: 50x100
Rms: 5 Bdrms: 3 Baths: 1 Gar: 0

HOUSE NO. 35 - Key Map #415Y
Address: 8837 Kentshire Case #27444
City: Houston Zip: 77078 Lot Size: 60x120
Rms: 6 Bdrms: 3 Baths: 1½ Gar: 1DG

HOUSE NO. 36 - Key Map #329R
Address: 9407 Kilkenny Case #430027
City: Spring Zip: 77379 Lot Size: 40x125
Rms: 6 Bdrms: 3 Baths: 2 Gar: 2AG

HOUSES TO BE SOLD JUNE 7, 1985

HOUSE NO. 37

Address 1786 Lakeshore Case #538913

City Humble Zip 77338 Lot Size Irr

Rms 6 | Bdrms 3 | Baths 1½ | Gar 2AG

HOUSE NO. 38 - Key Map #414X

Address 3901 Lakewood Case #26383

City Houston Zip 77093 Lot Size 60x100

Rms 7 | Bdrms 3 | Baths 1 | Gar 0

HOUSE NO. 39 - Key Map #414Y

Address 4410 Langley Case #24950

City Houston Zip 77016 Lot Size 50x247

Rms 5 | Bdrms 2 | Baths 1 | Gar 0

HOUSE NO. 40 - Key Map #455H

Address 8969 Las Cruces Dr Case #450021

City Houston Zip 77078 Lot Size Irr

Rms 5 | Bdrms 3 | Baths 1 | Gar 1CP

HOUSE NO. 41 - Key Map #415P

Address 11139 Ledford Ln Case #474843

City Houston Zip 77016 Lot Size 67x170

Rms 7 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 42 - Key Map #293A

Address 2502 Leichester Case #427541

City Spring Zip 77373 Lot Size 75x131

Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 43 - Key Map #293X

Address 3230 Lucide Ln Case #550656

City Spring Zip 77373 Lot Size 60x120

Rms 5 | Bdrms 2 | Baths 1½ | Gar 1AG

HOUSE NO. 44 - Key Map #371Q

Address 14122 Magnolia Spgs Case #503025

City Houston Zip 77066 Lot Size Irr

Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 45

Address 494 W. Magnolia Case #475736

City New Caney Zip 77357 Lot Size ¼ Acre

Rms 7 | Bdrms 3 | Baths 2 | Gar 2DG

HOUSE NO. 46 - Key Map #293W

Address 2335 Marble Falls Dr Case #433053

City Spring Zip 77373 Lot Size 65x115

Rms 5 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 47 - Key Map #371K

Address 3811 Mettingham Dr Case #553943

City Houston Zip 77066 Lot Size 55x105

Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 48 - Key Map #292D

Address 29507 Memorial Dr Case #389439

City Spring Zip 77373 Lot Size 65x100

Rms 9 | Bdrms 4 | Baths 2 | Gar 2AG

HOUSES TO BE SOLD JUNE 7, 1985

HOUSE NO. 49 - Key Map #457A
Address 13134 Nature Trail Case #537121
City Houston Zip 77044 Lot Size 47x110
Rms 5 | Bdrms 3 | Baths 2 | Gar 1AG

HOUSE NO. 50 - Key Map #456V
Address 6215 Northpost Case #435205
City Houston Zip 77049 Lot Size 60x115
Rms 5 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 51 - Key Map #455H
Address 9006 Oak Knoll Case #521197
City Houston Zip 77028 Lot Size 60x120
Rms 6 | Bdrms 3 | Baths 1 | Gar 2CP

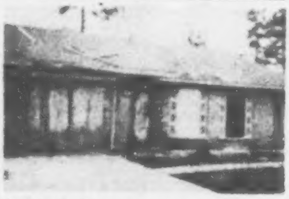
HOUSE NO. 52 - Key Map #371P
Address 3630 Oakhall Dr Case #515732
City Houston Zip 77066 Lot Size 60x105
Rms 4 | Bdrms 2 | Baths 2 | Gar 2AG

HOUSE NO. 53 - Key Map #414E
Address 3310 Otterbury Case #27014
City Houston Zip 77039 Lot Size 60x110
Rms 7 | Bdrms 3 | Baths 1½ | Gar 0

HOUSE NO. 54 - Key Map #453X
Address 416 Pecore Case #460134
City Houston Zip 77009 Lot Size 50x100
Rms 7 | Bdrms 3 | Baths 2 | Gar 2DG

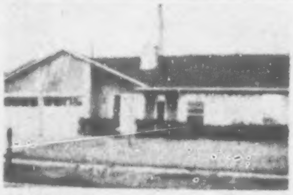
HOUSE NO. 55 - Key Map #456S
Address 10910 Penelope Case #26426
City Houston Zip 77013 Lot Size 130x178
Rms 5 | Bdrms 2 | Baths 1 | Gar 2DG

HOUSE NO. 56 - Key Map #293W
Address 2422 Piddler Dr Case #494160
City Spring Zip 77373 Lot Size 62x105
Rms 7 | Bdrms 4 | Baths 2 | Gar 2AG



HOUSE NO. 57 - Key Map #415P
Address 7103 Pinehood Ln Case #26479
City Houston Zip 77016 Lot Size 60x110
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 58 - Key Map #372U
Address 206 Plaza Verde Dr. D-11 Case #493378
City Houston Zip 77038 Lot Size N/A
Rms 5 | Bdrms 2 | Baths 2 | Gar 1CP



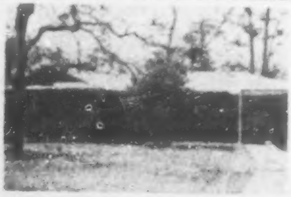
HOUSE NO. 59 - Key Map #293A
Address 29502 Raestone Case #385938
City Spring Zip 77386 Lot Size 75x100
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 60
Address 14414 Ravendale Case #26492
City Humble Zip 77338 Lot Size 60x140
Rms 7 | Bdrms 3 | Baths 2 | Gar 2DG

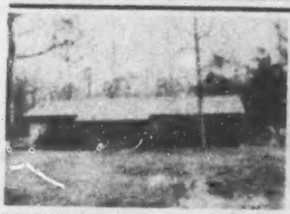
HOUSES TO BE SOLD JUNE 7, 1985

HOUSE NO. 61 - Key Map #369Y
Address: 9911 Rippling Fields Case #459886
City: Houston Zip: 77040 Lot Size: Irr.
Rms: 8 | Bdrms: 4 | Baths: 2 | Gar: 2AG

HOUSE NO. 62 - Key Map #418R
Address: 17750 Riverside Case #436200
City: Houston Zip: 77044 Lot Size: 100x100
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 2DG

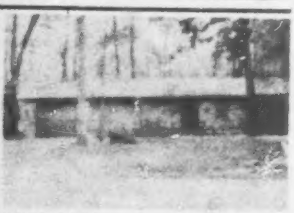


HOUSE NO. 63 - Key Map #414Z
Address: 10821 Rockaway Case #25393
City: Houston Zip: 77016 Lot Size: 60x110
Rms: 6 | Bdrms: 2 | Baths: 1 | Gar: 1CP



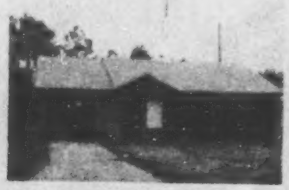
HOUSE NO. 64
Address: Rt. 1, Box 405X Case #430277
City: New Caney Zip: 77357 Lot Size: 100x150
Rms: 7 | Bdrms: 3 | Baths: 1 | Gar: 0

HOUSE NO. 65
Address: Rt. 1, Box 429-H Case #409315
City: New Caney Zip: 77355 Lot Size: 180x168
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0



HOUSE NO. 66
Address: Rt. 2, Box 258 Case #521068
City: New Caney Zip: 77357 Lot Size: Irr.
Rms: 7 | Bdrms: 3 | Baths: 1½ | Car: 1AG

HOUSE NO. 67 - Key Map #256R
Address: Rt. 4, Box 1380 Case #536451
City: New Caney Zip: 77357 Lot Size: 1.3 acre
Rms: 9 | Bdrms: 3 | Baths: 2 | Gar: 2DG



HOUSE NO. 68 - Key Map #413E
Address: 6511 Sandy Oaks Case #26847
City: Houston Zip: 77050 Lot Size: 60x110
Rms: 5 | Bdrms: 3 | Baths: 1½ | Gar: 1AG

HOUSE NO. 69 - Key Map #457U
Address: 14835 Shottery Dr. Case #520321
City: Houston Zip: 77015 Lot Size: Irr.
Rms: 6 | Bdrms: 4 | Baths: 2 | Gar: 2AG

HOUSE NO. 70 - Key Map #410D
Address: 7819 Smokey Wood Case #26146
City: Houston Zip: 77086 Lot Size: 60x105
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2AG

HOUSE NO. 71 - Key Map #415N
Address: 106 Sparkling Water Case #457379
City: Huffman Zip: 77336 Lot Size: Irr.
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2DG

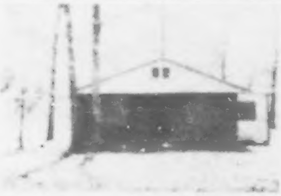
HOUSE NO. 72 - Key Map #415N
Address: 11131 Spottswood Dr. Case #26605
City: Houston Zip: 77016 Lot Size: 60x120
Rms: 6 | Bdrms: 3 | Baths: 1 | Gar: 1AG

HOUSES TO BE SOLD JUNE 7, 1985

HOUSE NO. 73 - Key Map #293X
Address 23222 Summer Pine Dr Case #570886
City Spring Zip 77373 Lot Size 42x133
Rms 4 | Bdrms 1 | Baths 1 | Gar 1AG

HOUSE NO. 74
Address 4631 Tealgate Case #570769
City Spring Zip 77373 Lot Size 42x133
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 75 - Key Map #293Y
Address 4623 Tealgate Dr Case #548718
City Spring Zip 77373 Lot Size 65x120
Rms 6 | Bdrms 4 | Baths 2 | Gar 2AG



HOUSE NO. 76
Address 4018 Trent Rd Case #498018
City Huffman Zip 77336 Lot Size 233x297
Rms 5 | Bdrms 2 | Baths 1 | Gar 0

HOUSE NO. 77 - Key Map #456A
Address 9927 Valley Mill Ct Case #475834
City Houston Zip 77078 Lot Size Irr
Rms 5 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 78 - Key Map #414Q
Address 5002 Van Zandt Case #25499
City Houston Zip 77093 Lot Size 120x150
Rms 6 | Bdrms 3 | Baths 2 | Gar 2DG

HOUSE NO. 79 - Key Map #371Q
Address 3319 Walhalla Dr Case #541258
City Houston Zip 77066 Lot Size 60x105
Rms 7 | Bdrms 4 | Baths 2 | Gar 2AG

HOUSE NO. 80 - Key Map #455E
Address 7942 Way Case #522235
City Houston Zip 77028 Lot Size 73x130
Rms 6 | Bdrms 2 | Baths 1 | Gar 0

HOUSE NO. 81 - Key Map #454H
Address 7117 Weyburn Case #458639
City Houston Zip 77038 Lot Size 60x120
Rms 6 | Bdrms 3 | Baths 1 | Gar 1DG

HOUSE NO. 82 - Key Map #370Z
Address 7746 Whidby Island Case #434607
City Houston Zip 77086 Lot Size 60x140
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 83 - Key Map #370V
Address 10903 Wilkenberg Dr Case #520799
City Houston Zip 77086 Lot Size 64x110
Rms 6 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSE NO. 84 - Key Map #371M
Address 2719 Winter Pk. Ct Case #551842
City Houston Zip 77067 Lot Size 60x110
Rms 7 | Bdrms 3 | Baths 2 | Gar 2AG

HOUSES TO BE SOLD JUNE 7, 1985

HOUSE NO. 85 - Key Map #4492

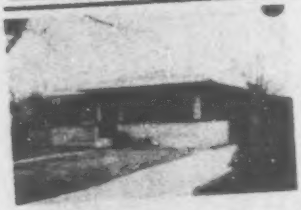
Address: 1118 Wisterwood Dr. Case #472323
City: Houston Zip: 77043 Lot Size: Irr
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2AG

HOUSE NO. 86

Address: 1438 D Woodlane Rd. Case #497684
City: Splendora Zip: 77372 Lot Size: 150x300
Rms: 6 | Bdrms: 2 | Baths: 1½ | Gar: 0

HOUSE NO. 87

Address: 114 Yupon Case #96517
City: Porter Zip: 77365 Lot Size: 100x250
Rms: 7 | Bdrms: 4 | Baths: 2 | Gar: 2AG



HOUSE NO. 88

Address: 1916 8th Ave. N. Case #400587
City: Texas City Zip: 77590 Lot Size: Irr.
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 1G1CP

HOUSES TO BE SOLD JUNE 8, 1985

HOUSE NO. 89
Address: 1911 36th Ave N Case #26672
City: Texas City Zip: 77590 Lot Size: 50x196
Rms: 5 Bdrms: 2 Baths: 1 Gar: 0

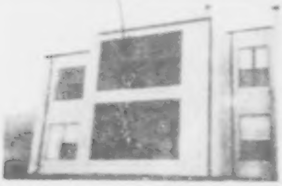
HOUSE NO. 90 - Key Map #598Q
Address: 13302 Barranca Dr Case #499661
City: Houston Zip: 77083 Lot Size: 45x115
Rms: 4 Bdrms: 2 Baths: 1 Gar: 0

HOUSE NO. 91 - Key Map #528U
Address: 9327 Barrowhollow Case #27483
City: Houston Zip: 77083 Lot Size: 45x110
Rms: 6 Bdrms: 3 Baths: 2 Gar: 0

HOUSE NO. 92 - Key Map #532Q
Address: 9824 S. Bartell 7 Case #500330
City: Houston Zip: 77054 Lot Size: N/A
Rms: 3 Bdrms: 1 Baths: 1 Gar: 1CP

HOUSE NO. 93 - Key Map #532Q
Address: 2530 S. Bartell 11 Case #566954
City: Houston Zip: 77054 Lot Size: N/A
Rms: 4 Bdrms: 2 Baths: 1 Gar: 1CP

HOUSE NO. 94 - Key Map #532Q
Address: 9832 S. Bartell 32-D Case #553107
City: Houston Zip: 77054 Lot Size: N/A
Rms: 3 Bdrms: 1 Baths: 1 Gar: 1CP



HOUSE NO. 95 - Key Map #532Q
Address: 9814 S. Bartell 15-10 Case #521145
City: Houston Zip: 77074 Lot Size: N/A
Rms: 4 Bdrms: 2 Baths: 1 Gar: 1CP

HOUSE NO. 96 - Key Map #598Q
Address: 13307 Bassford Dr Case #502830
City: Houston Zip: 77083 Lot Size: 45x111
Rms: 5 Bdrms: 2 Baths: 1 Gar: 0

HOUSE NO. 97 - Key Map #451C
Address: 6715 W. Bayou Dr Case #503014
City: Hitchcock Zip: 77563 Lot Size: 100x100
Rms: 6 Bdrms: 3 Baths: 2 Gar: 1AG

HOUSE NO. 98 - Key Map #534Y
Address: 6107 Belarbor Case #94882
City: Houston Zip: 77033 Lot Size: 56x110
Rms: 6 Bdrms: 3 Baths: 1 Gar: 1AG

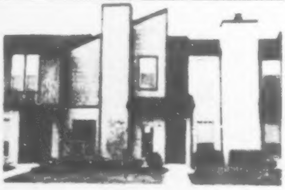
HOUSE NO. 99 - Key Map #534U
Address: 5819 Belcrest Case #458685
City: Houston Zip: 77033 Lot Size: 60x120
Rms: 6 Bdrms: 3 Baths: 1 Gar: 1AG

HOUSE NO. 100 - Key Map #534Y
Address: 6123 Belcrest Case #515925
City: Houston Zip: 77033 Lot Size: Irr
Rms: 7 Bdrms: 3 Baths: 1 Gar: 0

HOUSES TO BE SOLD JUNE 8, 1985

HOUSE NO. 101 - Key Map #536D
Address 708 E. Belmont Case #26106
City Pasadena Zip 77506 Lot Size 60x110
Rms 5 | Bdrms 3 | Baths 1 | Gar 1DG

HOUSE NO. 102 - Key Map #528R
Address 12400 Brookglade Cr. 69 Case #515463
City Houston Zip 77099 Lot Size 20x67
Rms 5 | Bdrms 2 | Baths 2½ | Gar 2DG



HOUSE NO. 103 - Key Map #528R
Address 12300 Brookglade Cr. 79 Case #524655
City Houston Zip 77099 Lot Size 20x90
Rms 5 | Bdrms 2 | Baths 2½ | Gar 2DG

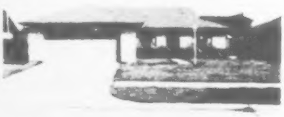
HOUSE NO. 104 - Key Map #528R
Address 12300 Brookglade Cr. 115 Cs #524876
City Houston Zip 77099 Lot Size 20x60
Rms 5 | Bdrms 2 | Baths 2½ | Gar 2DG

HOUSE NO. 105 - Key Map #497H
Address 254 Brookwood Case #479502
City Channelview Zip 77530 Lot Size 54x100
Rms 6 | Bdrms 3 | Baths 1½ | Gar 1AG

HOUSE NO. 106 - Key Map #5345
Address 5306 Burma Case #27478
City Houston Zip 77033 Lot Size 50x100
Rms 6 | Bdrms 3 | Baths 1 | Gar 1AG

HOUSE NO. 107 - Key Map #534N
Address 5414 Chennault Case #481604
City Houston Zip 77033 Lot Size 50x110
Rms 4 | Bdrms 2 | Baths 1 | Gar 1G1CP

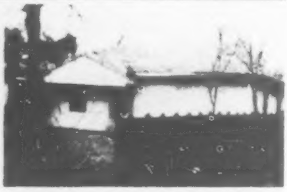
HOUSE NO. 108 - Key Map #574G
Address 10501 Chickadee Case #436740
City Houston Zip 77048 Lot Size 104x208
Rms 5 | Bdrms 2 | Baths 1 | Gar 1DG



HOUSE NO. 109 - Key Map #528X
Address 14106 Country Manor Dr. Cs #541912
City Sugarland Zip 77021 Lot Size 70x130
Rms 6 | Bdrms 3 | Baths 1½ | Gar 2CP

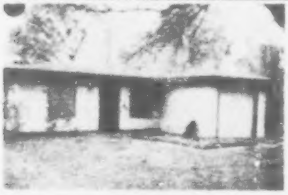
HOUSE NO. 110
Address 11801 Dale Case #523353
City Galveston Zip 77551 Lot Size 55x115
Rms 3 | Bdrms 1 | Baths 1 | Gar 0

HOUSE NO. 111 - Key Map #533V
Address 7906 Darnay Case #450706
City Houston Zip 77033 Lot Size 60x110
Rms 6 | Bdrms 3 | Baths 1 | Gar 1CP



HOUSE NO. 112 - Key Map #5345
Address 5009 Dieppe Case #16456
City Houston Zip 77033 Lot Size 50x110
Rms 4 | Bdrms 2 | Baths 1 | Gar 1G1CP

HOUSES TO BE SOLD JUNE 8, 1985



HOUSE NO. 113 - Key Map #5345
Address 5206 Dieppe Case #25492
City Houston Zip 77035 Lot Size 50x110
Rms 5 Bdrms 3 Baths 1 Gar 1AG

HOUSE NO. 114 - Key Map #497D
Address 815 Doncrest Case #431678
City Channelview Zip 77530 Lot Size 55x100
Rms 9 Bdrms 5 Baths 2 Gar 0

HOUSE NO. 115 - Key Map #5345
Address 5309 Doolittle Case #26201
City Houston Zip 77033 Lot Size 50x100
Rms 5 Bdrms 2 Baths 1 Gar 1CP

HOUSE NO. 116 - Key Map #534T
Address 5951 Doolittle Case #516756
City Houston Zip 77033 Lot Size 63x114
Rms 5 Bdrms 2 Baths 1 Gar 1 AG

HOUSE NO. 117 - Key Map #573F
Address 10759 Dulcimer Case #472663
City Houston Zip 77051 Lot Size Irr
Rms 7 Bdrms 3 Baths 1 Gar 2CP

HOUSE NO. 118 - Key Map #527F
Address 16314 Espinosa Case #492210
City Houston Zip 77083 Lot Size 55x110
Rms 6 Bdrms 3 Baths 2 Gar 2AG

HOUSE NO. 119 - Key Map #574J
Address 12123 Fawnway Case #23583
City Houston Zip 77048 Lot Size 60x100
Rms 7 Bdrms 3 Baths 1½ Gar 0

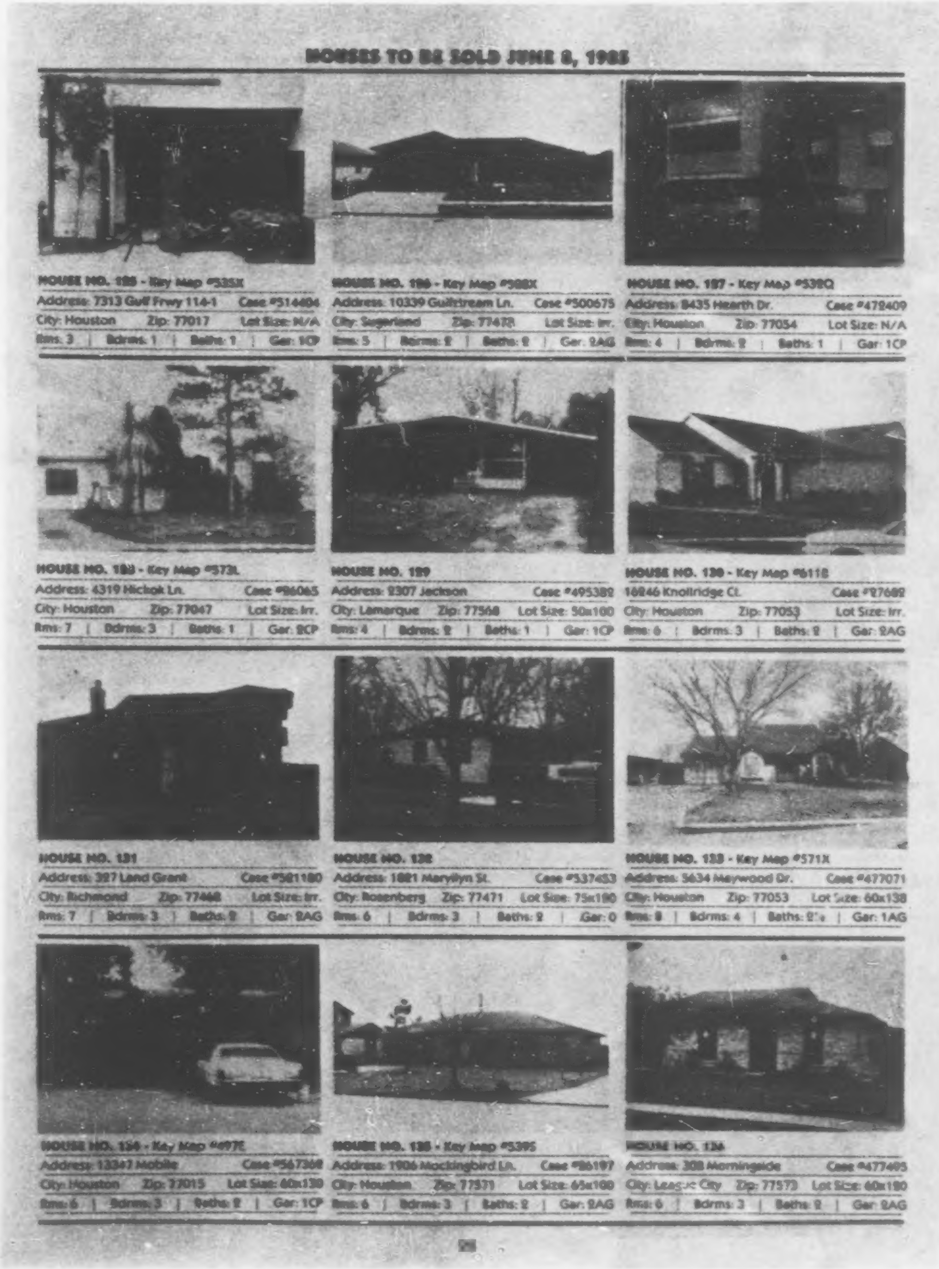
HOUSE NO. 120 - Key Map #458A
Address 16914 Folsom Dr Case #542842
City Houston Zip 77049 Lot Size Irr
Rms 6 Bdrms 3 Baths 2 Gar 2AG

HOUSE NO. 121 - Key Map #497A
Address 13338 Force Case #540054
City Houston Zip 77049 Lot Size 60x130
Rms 5 Bdrms 2 Baths 1 Gar 0

HOUSE NO. 122 - Key Map #529V
Address 10403 Forum Pk 34-A Case #495215
City Houston Zip 77036 Lot Size N/A
Rms 5 Bdrms 2 Baths 2 Gar 1CP

HOUSE NO. 123 - Key Map #534Y
Address 6534 Glenrock Case #587177
City Houston Zip 77087 Lot Size 100x120
Rms 7 Bdrms 3 Baths 2½ Gar 0

HOUSE NO. 124 - Key Map #535J
Address 7313 Gulf Frwy 1109 Case #543382
City Houston Zip 77017 Lot Size N/A
Rms 3 Bdrms 1 Baths 1 Gar 1CP



HOUSES TO BE SOLD JUNE 8, 1985

HOUSE NO. 125 - Key Map #535X
Address: 7313 Gulf Frwy 114-1 Case #514404
City: Houston Zip: 77017 Lot Size: N/A
Rms: 3 | Bdrms: 1 | Baths: 1 | Gar: 1CP

HOUSE NO. 126 - Key Map #508X
Address: 10339 Gulfstream Ln. Case #500675
City: Sugarland Zip: 77478 Lot Size: Irr.
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 2AG

HOUSE NO. 127 - Key Map #538Q
Address: 8435 Hearth Dr. Case #472409
City: Houston Zip: 77054 Lot Size: N/A
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1CP

HOUSE NO. 128 - Key Map #573L
Address: 4319 Hickok Ln. Case #86065
City: Houston Zip: 77047 Lot Size: Irr.
Rms: 7 | Bdrms: 3 | Baths: 1 | Gar: 2CP

HOUSE NO. 129
Address: 2307 Jackson Case #495382
City: Lamarque Zip: 77568 Lot Size: 50x100
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1CP

HOUSE NO. 130 - Key Map #611E
16246 Knollridge Ct. Case #27682
City: Houston Zip: 77053 Lot Size: Irr.
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2AG

HOUSE NO. 131
Address: 327 Land Grant Case #521180
City: Richmond Zip: 77469 Lot Size: Irr.
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 2AG

HOUSE NO. 132
Address: 1821 Marylyn St. Case #537453
City: Rosenberg Zip: 77471 Lot Size: 75x180
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 0

HOUSE NO. 133 - Key Map #571X
Address: 5634 Maywood Dr. Case #477071
City: Houston Zip: 77053 Lot Size: 60x138
Rms: 8 | Bdrms: 4 | Baths: 2½ | Gar: 1AG

HOUSE NO. 134 - Key Map #497E
Address: 13347 Mobile Case #567368
City: Houston Zip: 77015 Lot Size: 60x130
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 1CP

HOUSE NO. 135 - Key Map #539S
Address: 1906 Mockingbird Ln. Case #86197
City: Houston Zip: 77571 Lot Size: 65x100
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2AG

HOUSE NO. 136
Address: 308 Morningside Case #477495
City: League City Zip: 77573 Lot Size: 60x180
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2AG

HOUSES TO BE SOLD JUNE 8, 1985

HOUSE NO. 137 - Key Map #657Y
Address 407 Morningside Case #481091
City League City Zip 77573 Lot Size 60x115
Rms 6 Bdrms 2 Baths 2½ Gar 2AG

HOUSE NO. 138 - Key Map #573H
Address 10714 Mosscrest Case #25583
City Houston Zip 77048 Lot Size 60x100
Rms 6 Bdrms 3 Baths 1½ Gar 1AG

HOUSE NO. 139 - Key Map #533U
Address 1107 Niagra St Case #499911
City Houston Zip 77051 Lot Size 70x150
Rms 5 Bdrms 2 Baths 1 Gar 1AG

HOUSE NO. 140 - Key Map #534N
Address 5714 Northridge Case #519504
City Houston Zip 77033 Lot Size 65x110
Rms 6 Bdrms 2 Baths 1 Gar 1AG

HOUSE NO. 141 - Key Map #536Q
Address 2007 Oaks Dr Case #454102
City Pasadena Zip 77502 Lot Size 100x100
Rms 5 Bdrms 3 Baths 2 Gar 2AG

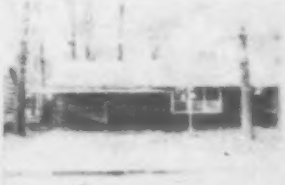
HOUSE NO. 142 - Key Map #574N
Address 5914 E. Orem Case #26256
City Houston Zip 77054 Lot Size 60x110
Rms 7 Bdrms 3 Baths 2 Gar 2AG

HOUSE NO. 143 - Key Map #574E
Address 5526 E. Osprey Case #472340
City Houston Zip 77048 Lot Size 60x119
Rms 5 Bdrms 3 Baths 2 Gar 1AG

HOUSE NO. 144 - Key Map #533Z
Address 8158 Paney Case #408167
City Houston Zip 77033 Lot Size Irr
Rms 6 Bdrms 3 Baths 1½ Gar 2CP

HOUSE NO. 145 - Key Map #573R
Address 12807 Peney Case #26499
City Houston Zip 77048 Lot Size 55x110
Rms 6 Bdrms 3 Baths 1½ Gar 1AG

HOUSE NO. 146 - Key Map #457V
Address 15103 Peachmeadow Case #523081
City Channelview Zip 77530 Lot Size 60x140
Rms 6 Bdrms 3 Baths 2 Gar 2AG



HOUSE NO. 147 - Key Map #497E
Address 13009 Peoria Case #430136
City Houston Zip 77015 Lot Size 60x140
Rms 7 Bdrms 3 Baths 1 Gar 2AG

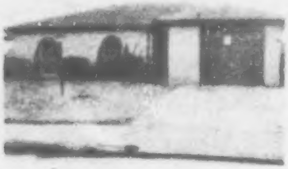
HOUSE NO. 148 - Key Map #533V
Address 4848 Pershing Case #96404
City Houston Zip 77033 Lot Size 55x110
Rms 8 Bdrms 4 Baths 2 Gar 1AG

HOUSES TO BE SOLD JUNE 8, 1985

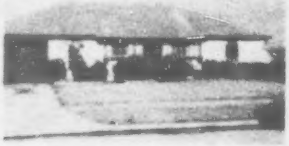
HOUSE NO. 149 - Key Map #534S
Address 5030-5030½ Pershing Case #517965
City Houston Zip 77033 Lot Size 59x120
Rms 7 Bdrms 3 Baths 2 Gar 0

HOUSE NO. 150 - Key Map #610C
Address 16506 Quail Run Dr Case #26881
City Missouri City Zip 77489 Lot Size 62x110
Rms 7 Bdrms 4 Baths 2 Gar 2AG

HOUSE NO. 151
Address 4907 Quebec Blvd Case #520048
City Richmond Zip 77469 Lot Size 59x110
Rms 5 Bdrms 3 Baths 2 Gar 2AG



HOUSE NO. 152 - Key Map #611D
Address 4905 E Ridgecreek Case #27446
City Houston Zip 77053 Lot Size 60x110
Rms 6 Bdrms 3 Baths 2 Gar 1AG



HOUSE NO. 153 - Key Map #611C
Address 4902 Ridge Creek Cr Case #26638
City Houston Zip 77053 Lot Size 70x100
Rms 6 Bdrms 3 Baths 1½ Gar 1AG

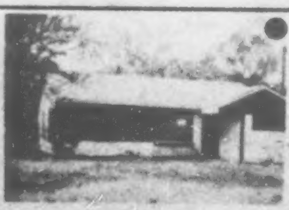
HOUSE NO. 154 - Key Map #611C
Address 4810 Ridgeton Case #493576
City Houston Zip 77087 Lot Size 60x110
Rms 7 Bdrms 3 Baths 2 Gar 2AG

HOUSE NO. 155 - Key Map #461S
Address 7419 Seminole Case #524317
City Baytown Zip 77520 Lot Size 68x105
Rms 5 Bdrms 3 Baths 2 Gar 2AG

HOUSE NO. 156 - Key Map #536N
Address 5539 Shamrock Case #26085
City Houston Zip 77017 Lot Size 60x100
Rms 6 Bdrms 3 Baths 1 Gar 0

HOUSE NO. 157 - Key Map #534W
Address 8138 Sharondale Case #26510
City Houston Zip 77033 Lot Size 60x150
Rms 6 Bdrms 2 Baths 1½ Gar 2DG

HOUSE NO. 158 - Key Map #[illegible]
Address 12465 Sharpview Case #407231
City Houston Zip 77078 Lot Size 38x58
Rms 4 Bdrms 2 Baths 2 Gar 1CP



HOUSE NO. 159 - Key Map #534P
Address 5518 South Lea Case #470969
City Houston Zip 77033 Lot Size 53x110
Rms 5 Bdrms 2 Baths 1 Gar 0

HOUSE NO. 160 - Key Map #534P
Address 5965 Southmont Case #524486
City Houston Zip 77033 Lot Size 60x110
Rms 6 Bdrms 2 Baths 1 Gar 0

HOUSES TO BE SOLD JUNE 8, 1985

HOUSE NO. 161
Address 506 Stonewall Case #494719
City Richmond Zip 77469 Lot Size 60x105
Rms 6 Bdrms 3 Baths 1½ Gar 1AG

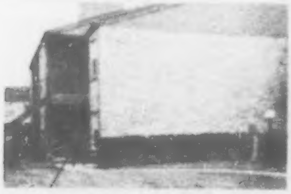
HOUSE NO. 162
Address 607 Tora Plantantion Case #565111
City Richmond Zip 77469 Lot Size 60x105
Rms 6 Bdrms 3 Baths 2 Gar 2AG

HOUSE NO. 163 - Key Map #497D
Address 15003 Tippicrest Dr Case #90151
City Channelview Zip 77530 Lot Size 52x120
Rms 7 Bdrms 4 Baths 2 Gar 2AG

HOUSE NO. 164 - Key Map #528X
Address 13818 Townewest Dr Case #536904
City Sugarland Zip 77478 Lot Size 65x115
Rms 7 Bdrms 3 Baths 2 Gar 2AG

HOUSE NO. 165 - Key Map #571M
Address 4315 Trail Lake Case #480957
City Houston Zip 77045 Lot Size 61x110
Rms 6 Bdrms 3 Baths 1 Gar 2AG

HOUSE NO. 166 - Key Map #572K
Address 3327 Trailake Case #26908
City Houston Zip 77054 Lot Size 62x115
Rms 5 Bdrms 3 Baths 1 Gar 1AG



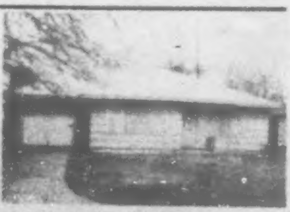
HOUSE NO. 167 - Key Map #529G
Address 10555 Turtlewd Ct 2419 Cs #539713
City Houston Zip 77072 Lot Size N/A
Rms 4 Bdrms 2 Baths 2 Gar 1CP

HOUSE NO. 168 - Key Map #529G
Address 10555 Turtlewd Ct 2509 Cs #544589
City Houston Zip 77072 Lot Size N/A
Rms 4 Bdrms 1 Baths 1 Gar 1CP

HOUSE NO. 169 - Key Map #529L
Address 10555 Turtlewd Ct 2508 Cs #540906
City Houston Zip 77072 Lot Size N/A
Rms 3 Bdrms 1 Baths 1 Gar 1CP

HOUSE NO. 170 - Key Map #529G
Address 10555 Turtlewd Ct 2508 Cs #550605
City Houston Zip 77072 Lot Size N/A
Rms 4 Bdrms 2 Baths 2 Gar 1CP

HOUSE NO. 171 - Key Map #533K
Address 6985 Van Eden Case #496080
City Houston Zip 77081 Lot Size 70x130
Rms 6 Bdrms 3 Baths 1½ Gar 2CP



HOUSE NO. 172 - Key Map #534X
Address 6119 Westover Case #493273
City Houston Zip 77033 Lot Size Irr.
Rms 5 Bdrms 2 Baths 1 Gar 1AG

HOUSES TO BE SOLD JUNE 8, 1985

HOUSE NO. 173 - Key Map #536X

Address 907 Kaupon Case #96575

City Pasadena Zip 77502 Lot Size 60x110

Rms. 6 Bdrms. 2 Baths 1 Gar. 1AG

HOUSE NO. 174 - Key Map #617R

Address 15534 Zabrina 101-A Case #554334

City Webster Zip 77598 Lot Size N-a

Rms. 5 Bdrms. 2 Baths 2 Gar. 1CP

HOUSE NO. 175

Address 2107 Zieglers Grove Case #5377192

City Richmond Zip 77469 Lot Size 60x110

Rms. 6 Bdrms. 3 Baths 2 Gar. 2AG

HOUSTON AUCTION
OF
VETERANS ADMINISTRATION PROPERTIES

February 8 and 9, 1986

LARRY LATHAM AUCTIONEERS, INC.
10101 SOUTH LOOP FREEWAY WEST, 1 STERLING PLAZA
HOUSTON, TEXAS
PHONE 713/541-0933

Auction Information

DATES:
Saturday, February 8, 1986 at 10:00 a.m.
(Registration 8:00 a.m.)

★★★

Sunday, February 9, 1986 at 1:00 p.m.
(Registration 11:00 a.m.)

LOCATION:
WESTIN GALLERIA
5060 W. Alabama, Houston, Texas

AUCTION HOTLINE

(713) 541-0933

LARRY LATHAM
AUCTIONEERS

WELCOME TO THE HOUSTON VA AUCTION!

Thank you for attending our Houston VA Auction. We welcome all of you and specifically invite each of you to bid on and purchase any of the 250 homes that will be offered in this Two Day Auction for the Veterans Administration.

These properties are an excellent investment opportunity for any homebuyer or for the investor looking to expand his or her portfolio. Some of these properties are in need of repair, with the degree of repair varying. This Auction is not a mortgage sale but is a sale of government-owned property for which good title has been obtained.

Should you have questions about our auction methods or procedures, please feel free to ask questions and make inquiries of any of our staff members.

Again, welcome to our Auction.

Sincerely,

Larry W. Latham

LARRY W. LATHAM, PRESIDENT
LARRY LATHAM AUCTIONEERS, INC.

INVITATION TO BID

The Staff of Larry Latham Auctioneers, Inc. welcomes you to our Houston Auction. To help you feel more comfortable, the following is a brief outline of our Auction process:

1. All bidders are to register at the door prior to entering the Ballroom. You will be required to show your cash or Certified Check or Cashier's Check made payable to "The Veterans Administration." After your check has been shown to the clerk, you will be given a Bidder Card with an assigned number on it. Please keep your Bidder Card because this will be your number for the Auction. You cannot bid without a Bidder Card.

2. Because of the large crowd expected, each registered Bidder may only have one guest in the Bidders' Section of the ballroom.

3. The Auctioneer will make all necessary announcements covering the Auction procedures and any changes that may need to be made prior to taking the first bid. All announcements made at the Auction take precedence over all printed material.

4. The Auctioneer will invite any questions or inquiries prior to taking the first bid.

5. The bidding will begin with House #1. The Auctioneer will ask for any opening bid. If you would like to bid, simply raise your Bidder Card in the air and shout your bid to the Auctioneer or the Ringperson nearest you. Each time, the Auctioneer will give the last bid and ask for the next highest dollar bid. As each house comes under the Auction gavel, the house number and address will be announced and a color slide and number will be shown for reference. The houses will be auctioned in the same sequence as they appear in this catalogue.

6. Bidding will continue on each house until all bidding ceases, and the house will be sold to the highest final Bidder. The Auctioneer shall determine if a tie-bid has occured and will make the final determination as to whether to re-open the bidding and break the tie. VA reserves the right to accept or reject all final bids. After the final bid has been taken, the Auctioneer will again state the property address, your Bidder Card Number and the Final Sales Price which will contractually bind you as the Purchaser.

7. If you have been the successful Bidder, you will go immediately to the Closing Room and sign all necessary Documents to obtain your property. At that time, you will turn in your $2,000 Bid Card, make your $2,000 Downpayment and schedule a Closing Appointment within 30 days to pay the balance of the purchase price and receive your deed. If you intend to bid on other properties, a Ringperson will bring the necessary information to you and stamp or pickup your Bid Card along with the Certified Check or Cashier's Check and give you a receipt. The Ringperson will also request that you sign the appropriate Documents. Immediately after the Auction, before you leave, you must schedule a Closing Date with the Closing Agent.

Texas Auctioneer's License: AIE-016-1878 (Larry W. Latham)
Texas Real Estate Broker's License: 230841 (Dudley N. Althaus)

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AUCTION TERMS AND CONDITIONS OF SALE

1. **BIDDING:** All bidding is open to the public without regard to race, color, sex, religion or national origin. All sales will be cash, "as is", and **must close within 45 days.** Employees of the Houston VA Regional Office and employees of Larry Latham Auctioneers, Inc., and its affiliates, are specifically prohibited from bidding on or purchasing any property offered in this sale.
2. **BIDDER'S CARD; 10% DOWN PAYMENT:** In order to obtain a bidder's card, you will be required to show to the clerk your **Certified or Cashier's Check or cash in the amount of $2,000.** All checks are to be payable to "The Veteran's Administration". You must have a separate check in the amount of $2,000 for each dwelling that you wish to purchase. If $2,000 is less than 10% of the total price, then **the purchaser must deposit the balance of the 10% by 5:00 p.m. on February 11, 1986.** Only the successful high bidder on each property will be required to deposit with VA the cash or Certified or Cashier's Check in the amount of $2,000 for each house.
3. **CLOSING:** The successful bidder must sign all documents and contracts **immediately upon the conclusion of bidding.** If your bid is accepted, you will be required to make an appointment with the closing agent to pay the balance of your purchase price and receive the deed to your property. **The VA is offering no financing** on the auction properties. For those buyers not obtaining outside financing, closings must take place on or before **5:00 p.m. on Friday, February 21, 1986.** Payment in full must be made of the downpayment will be forfeited. For those buyers who are obtaining outside financing, a letter of verification from the outside lending institution must be received by Larry Latham Auctioneers at One Sterling Plaza, Suite 445, Houston, TX 77074, postmarked on or before **Wednesday, February 19, 1986** or the downpayment will be forfeited. All closings with such financing must close on or before **Wednesday, March 26, 1986** or the downpayment will be forfeited.
4. **DEFAULT:** If closing is delayed by actions or lack of actions or failure to comply with these Auction Terms and Conditions of Sale by the buyer, default will be declared and the downpayment will be retained by VA and Larry Latham Auctioneers, Inc. as liquidated damages, the exact damages being unable to be determined in advance.
5. **BID ACCEPTANCE:** All final bids are subject to acceptance by the Veterans Administration. While we feel that all reasonable offers will be entertained, VA retains the right to accept or reject all final bids. There is no minimum opening bid on any property.
6. **PRO-RATIONS:** Real estate taxes, community association dues, if any, and water and sewer charges, if any, will be prorated as of date of closing, and all closing costs are at the sole expense of the purchaser.
7. **AUCTION PROCEDURE:** Announcements made on the day of the auction will take precedence over all printed material. Method, order of sale and bidding increments shall be at the sole discretion of the auctioneer. Reopening of tie bids shall be determined by the auctioneer.
8. **ALTERNATE FINANCING:** Alternate financing from sources other than VA may be available to qualified buyers. VA will not itself be offering financing on any auction properties. For information on obtaining financing, call (713) 541-0933.
9. **PROPERTY INSPECTION; AS IS — WHERE IS:** VA and Larry Latham Auctioneers, Inc. assume the bidders have inspected the properties prior to the auction date. These properties are offered for sale "**AS IS -WHERE IS**", unrepaired and without any expressed or implied warranties. Larry Latham Auctioneers, Inc. and Veterans Administration assume no liability for errors or omissions in this or any other property listing or advertising or promotional/publicity statements and material. Although information has been obtained from sources deemed reliable, the auctioneer makes no guarantee as to the accuracy of the information herein contained or in any other property listing or advertising or promotional/publicity statement and material.

BROKER PARTICIPATION

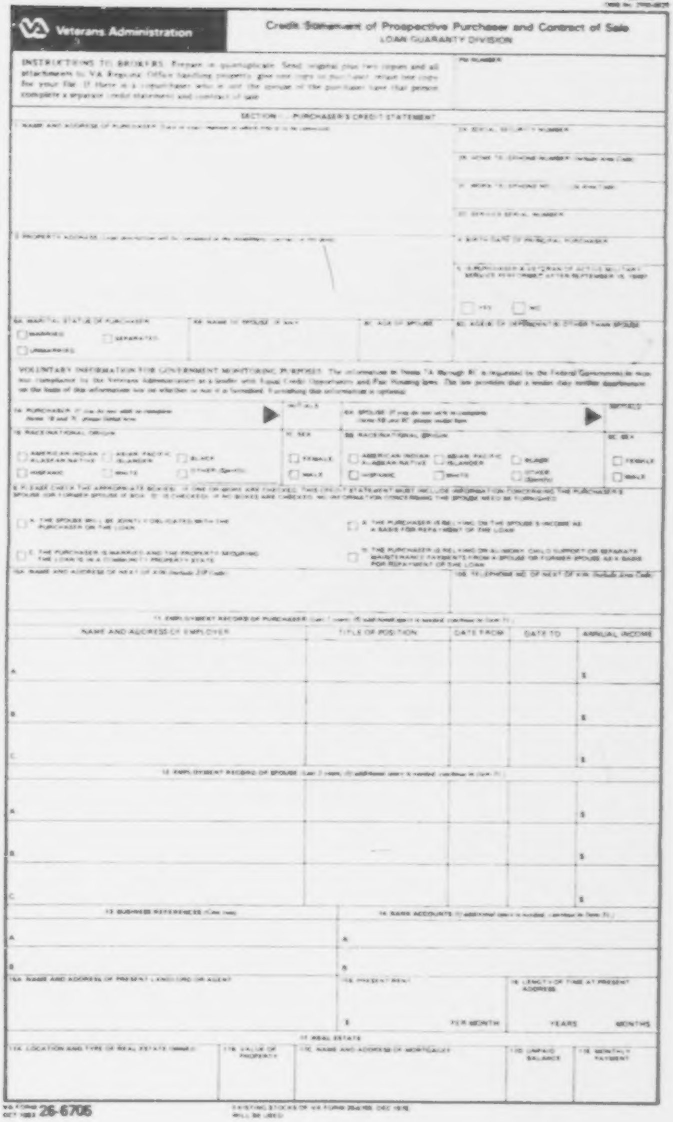
A 2% commission per property will be paid to the Registered Approved Broker whose prospect purchases the property at the auction and closes that property. **To qualify for the commission the following pre-registration requirements must all be met:**

1. A licensed real estate broker must both express an willingness to become a participating broker in this auction and must also register his or her designated salespeople by writing to Larry Latham Auctioneers, Inc. submitted BY MAIL, postmarked **no later than January 30, 1986** at the following address: Larry Latham Auctioneers, One Sterling Plaza, Suite 445, 10101 Southwest Freeway, Houston, TX 77074.
2. The approved Broker must then register each prospect with Larry Latham Auctioneers by completing in full the official "Broker Participation Form" (signed by the Approved Broker, the Approved Salesperson and the Prospect.) The Broker Participation Form is available by mail or at the above address. The completed Broker Participation Form must be received by Larry Latham Auctioneers at the above address by **5:00 p.m. on Friday, January 30, 1986.**
3. The Approved Broker (or Approved Salesperson) must attend the auction and sign in with the prospect on each day of the auction, specifically naming that prospect as a client.
4. In cases where a prospect has inspected a house on more than one occasion with different brokers, the letter received by Larry Latham Auctioneers with the earliest postmark shall be the determining factor in deciding which broker will qualify for commission earned if the prospect becomes the successful bidder for that house at the auction.
5. No commission on property will be paid to any licensed broker participating in the purchase of the property, and an affidavit shall be required stating that the licensed broker is serving only as an agent for the buyer and not as a principal involved in the purchase.
6. No commission will be paid for any backup bid purchases. No commission on any property will be paid to any broker currently suspended or disbarred from participating in VA programs. No commission will be paid to any broker whose license has been suspended or who has been disbarred by any Texas real estate governing authority.
7. The commission will be paid to the Approved Broker as soon as Larry Latham Auctioneers has been paid by the VA.
8. There can be **NO EXCEPTIONS** to this procedure, and **NO ORAL REGISTRATION** will be accepted.

VETERANS
ADMINISTRATION

EQUAL HOUSING
OPPORTUNITY

The following Documents are required for the purchase of VA Single Family Homes. These documents will be furnished to the successful Bidder on each property by our Closing Agent at the time of sale.



Veterans Administration

Credit Statement of Prospective Purchaser and Contract of Sale

LOAN GUARANTY DIVISION

INSTRUCTIONS TO BROKERS

SECTION I — PURCHASER'S CREDIT STATEMENT

☐ YES ☐ NO

6A. MARITAL STATUS OF PURCHASER
☐ MARRIED ☐ SEPARATED
☐ UNMARRIED

VOLUNTARY INFORMATION FOR GOVERNMENT MONITORING PURPOSES

7B. RACE/NATIONAL ORIGIN
☐ AMERICAN INDIAN ALASKAN NATIVE ☐ ASIAN PACIFIC ISLANDER ☐ BLACK
☐ HISPANIC ☐ WHITE ☐ OTHER (Specify)

7C. SEX
☐ FEMALE
☐ MALE

8B. RACE/NATIONAL ORIGIN
☐ AMERICAN INDIAN ALASKAN NATIVE ☐ ASIAN PACIFIC ISLANDER ☐ BLACK
☐ HISPANIC ☐ WHITE ☐ OTHER (Specify)

8C. SEX
☐ FEMALE
☐ MALE

11. EMPLOYMENT RECORD OF PURCHASER

NAME AND ADDRESS OF EMPLOYER	TITLE OF POSITION	DATE FROM	DATE TO	ANNUAL INCOME
A.				$
B.				$
C.				$

12. EMPLOYMENT RECORD OF SPOUSE

A.				$
B.				$
C.				$

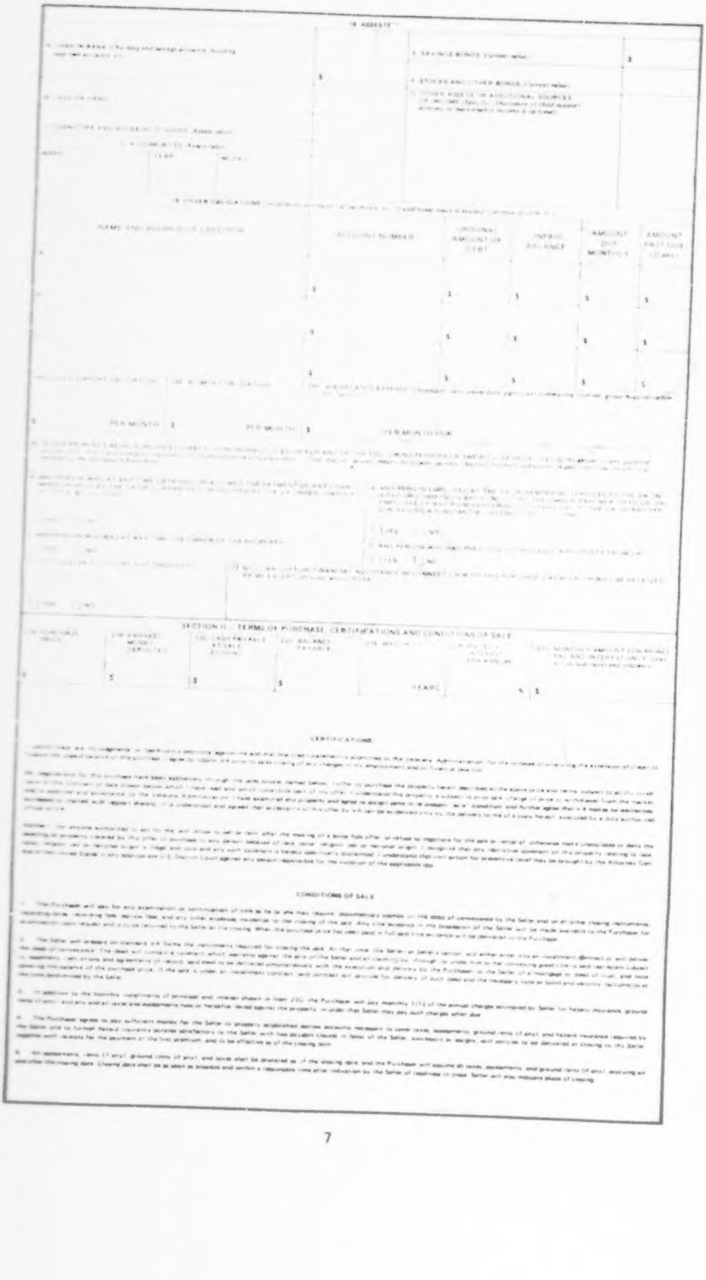
13. BUSINESS REFERENCES	14. BANK ACCOUNTS
A.	A.
B.	B.

15B. PRESENT RENT $ PER MONTH

16. LENGTH OF TIME AT PRESENT ADDRESS YEARS MONTHS

17. REAL ESTATE

VA FORM OCT 1983 26-6705



SAVINGS BONDS (Current value)

STOCKS AND OTHER BONDS (Current value)

NAME AND ADDRESS OF CREDITOR	ACCOUNT NUMBER	ORIGINAL AMOUNT OF DEBT	UNPAID BALANCE	AMOUNT DUE MONTHLY	AMOUNT PAST DUE
	$	$	$	$	$
	$	$	$	$	$
	$	$	$	$	$

PER MONTH $

PER MONTH $

PER MONTH FOR

☐ YES ☐ NO

☐ YES ☐ NO

☐ YES ☐ NO

SECTION II – TERMS OF PURCHASE, CERTIFICATIONS AND CONDITIONS OF SALE

$ | $ | $ | YEARS | % | $

CERTIFICATIONS

CONDITIONS OF SALE

CONDITIONS OF SALE (Continued)

6. This sale is subject to the rights of any parties in possession.

7. If the Purchaser refuses, or otherwise fails, to perform in accordance with this Contract of Sale, the Seller may, at the Seller's sole option, retain the earnest money deposited herewith as liquidated damages.

8. Should the Purchaser make valid objection to the title prior to the closing of the sale and the Seller be unable or unwilling to remove or comply with such objection, or should the Seller be unable to deliver the property vacant if so stipulated herein, or in the event of disagreement with respect to any other provision of the sale, the Seller may at any time rescind this Contract of Sale, in which event the earnest money deposited by the Purchaser will be returned. The return of the earnest money shall release the Seller from any and all claims arising from this transaction.

9. In the event the property herein described has not been acquired or the title thereto has not been approved by the Seller, then this contract is contingent upon such acquisition and approval of title by the Seller. In the event such property is subject to outstanding redemption rights and such rights are exercised, the Seller shall be entitled to the redemption money and shall return to the Purchaser all payments made by him or her to the Seller on account of this sale, without interest, less the fair rental value and thereupon there shall be no further liability hereunder between the parties hereto.

10. Risk of loss or damage by fire or other casualty is assumed by the Seller until the sale transaction is closed. If the property is damaged prior to the date of closing, the Seller reserves the right to terminate this contract upon returning to the Purchaser all deposits received by the Seller or the Broker.

11. The Purchaser will inform the Seller of any changes in employment and/or financial position, including bankruptcy, judgments, pending litigation, wages tax liens, assignment for the benefit of creditors, and other similar matters. In the event the Seller, in his or her sole opinion, shall have determined that the Purchaser's credit standing at any time prior to sale closing no longer warrants extension of credit contemplated hereunder, the Seller may rescind this Contract of Sale. The return of the earnest money deposited by the Purchaser shall release the Seller from any and all claims arising from this transaction.

12. This Contract of Sale contains the final and entire agreement between the parties hereto and they shall not be bound by any terms, conditions, statements, or representations, oral or written, not herein contained. This Contract of Sale is not assignable by the Purchaser.

13. Purchaser acknowledges that he or she has read and agrees to the entire Contract of Sale, including these conditions.

PRIVACY ACT INFORMATION The information collected on this form will serve as a credit application and Contract of Sale for a VA acquired property. The acquisition and sale of such property is authorized by law (38 U.S.C. 1820(a)(5)). You are not required to furnish the information, including the Social Security Number, but are urged to do so, since it is vital to proper action by VA in processing your application to purchase the subject property. The information submitted may be disclosed outside the Veterans Administration only as permitted by law. Responses may be disclosed outside the VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in VA system of records 55VA26, Loan Guaranty Home, Condominium and Manufactured Home Loan Applicant Records and Paraplegic Grant Application Records - VA, published in the Federal Register.

24A. DATE SIGNED	24B. SIGNATURE OF PROSPECTIVE PURCHASER
25A. DATE SIGNED	25B. SIGNATURE OF SPOUSE

SECTION III – RECEIPT FOR DEPOSIT AND TRANSMITTAL OF OFFER BY SALES BROKER TO THE VETERANS ADMINISTRATION

26. NAME OF SALES BROKER *(Type or print)*	27A. ADDRESS OF SALES BROKER *(Type or print)*	27B. TELEPHONE NO. OF SALES BROKER *(Include Area Code)*

- I, the undersigned sales broker, have received from the prospective purchaser the deposit shown in Item 23B which I am holding for the Veterans Administration for disposition as instructed by VA. *I agree that I am acting in the capacity of Trustee of these funds which will be placed by me in a separate bank account.* If this purchase offer is accepted by VA, this deposit shall be transmitted by me to VA for retention by VA. If the purchase offer is not accepted by VA, the deposit shall be returned to the prospective purchaser, without interest.
- The statements of the prospective purchaser in Sections I and II are believed to be true and correct. *I do not know of any loans, gifts, or financial assistance being made to the prospective purchaser. I will disclose to VA any such coming to my attention.*
- I understand and agree that the sales commission shall not be deemed earned unless and until the sale is actually closed, and also that the sales commission shall be payable in amount and time as established by VA. I understand and agree that no sales commission is payable if the purchaser is a VA-affiliated sales broker, an associated sales person or an employee of a VA-affiliated sales broker, including a spouse or close family member of such persons. No commission will be payable to any sales agent when the purchaser falls within one of these specified categories.
- I certify that neither I nor anyone authorized to act for me has declined to sell this property or to make it available for inspection or consideration by a prospective purchaser because of race, color, religion, sex, or national origin.

PROMPT PAYMENT NOTICE The provisions of FPR 1-29.202-1, FPR 1-29.301-4, and FPR 1-29.104 are incorporated by reference. Payments under this contract will be due on the ______________ calendar day after the receipt of a proper invoice or after acceptance of goods or services by VA whichever is later. For the purpose of determining the payment due date, a technical acceptance inspection will be completed within ______________ calendar days of delivery of the goods, or services provided under the contract.

28. CREDIT REPORT ☐ ATTACHED ☐ ORDERED ☐ NOT ORDERED	29A. DATE SIGNED	29B. SIGNATURE OF SALES BROKER	29C. RACE/NATIONAL ORIGIN OF SALES BROKER ☐ AMERICAN INDIAN ALASKAN NATIVE ☐ WHITE ☐ HISPANIC ☐ BLACK ☐ ASIAN, PACIFIC ISLANDER ☐ OTHER *(Specify)* ______

PENALTY The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

SECTION IV – ACCEPTANCE BY VETERANS ADMINISTRATION

Acceptance of this offer is hereby evidenced by my signature below and by the return to the purchaser of a copy hereof, as signed. (If offer is not accepted it will not be signed in Item 30B on behalf of VA and the prospective purchaser will be notified of the rejection.)

30A. DATE SIGNED	30B. THE ADMINISTRATOR OF VETERANS AFFAIRS By Loan Guaranty Officer

VA Form 26-6444a (October 1967)
Section 1820, Title 38, U.S.C.

TEXAS

STATE OF TEXAS,

County of

KNOW ALL MEN BY THESE PRESENTS that the Administrator of Veterans' Affairs, an Officer of the United States of America, whose address is Veterans Administration, Washington, D. C. 20420, hereinafter called Grantor for and in consideration of the sum of ten dollars ($10.00) and other valuable consideration

to him paid, and secured to be paid, by

hereinafter called Grantee(s), as follows:

has granted, sold, and conveyed, and by these presents does grant, sell, and convey unto the said Grantee(s) of

the County of , State of

all that certain tract or parcel of land in the County of , Texas, described as follows, to wit:

TO HAVE AND TO HOLD the above-described premises, together with all and singular, the rights and appurtenances thereto in anywise belonging unto the said Grantee(s) and Grantee's successors or heirs and assigns forever, and Grantor does hereby bind himself and his successors to warrant and forever defend all and singular the said premises unto the said Grantee(s) and Grantee's successors or assigns, against every person whomsoever lawfully claiming, or to claim the same or any part thereof, by, through, or under Grantor.

"But it is expressly agreed and stipulated that the Vendor's Lien is retained against the above-described property, premises, and improvements, until the above-described note and all interest thereon are fully paid according to face and tenor, effect and reading, when this deed shall become absolute."

IN WITNESS WHEREOF, Grantor, on the day of A.D. 19 , has caused this instrument to be signed and sealed in his name and on his behalf by the undersigned Loan Guaranty Officer, being thereunto duly appointed, qualified, and acting pursuant to sections 212 and 1820 of Title 38, United States Code, and sections 36:4342 and 36:4520 of the regulations pursuant thereto as amended, and who is authorized to execute this instrument.

As Administrator of Veterans' Affairs

*By

Loan Guaranty Officer

Authorization recorded in volume of the records of the County in which the above-described property is situated at page

THE STATE OF TEXAS,
County of

BEFORE ME, the undersigned authority on this day personally appeared known to me to be the person whose name is subscribed to the foregoing instrument, who, being by me duly sworn, did say that he is a Loan Guaranty Officer of the Veterans Administration, an agency of the United States Government, and is duly authorized to execute this deed on behalf of the Grantor, the Administrator of Veterans' Affairs named, and acknowledged to me that he subscribed the name of said Administrator thereto and that he executed such instrument on behalf of said Administrator for the purposes and consideration therein expressed, and in the capacity stated.

GIVEN UNDER MY HAND AND SEAL OF OFFICE THIS THE , day of , A.D. 19

[L.S.]

Notary Public in and for
County, Texas.

[illegible]

[illegible]

CLERK'S CERTIFICATE

THE STATE OF TEXAS,
County of | ss:

I, , County Clerk of the County Court of said County, do hereby certify that the foregoing instrument of writing dated on the day of , A.D. 19 , with its Certificate of Authentication, was filed for record in my office on the day of , A.D. 19 , at o'clock M., and duly recorded this day of , A.D. 19 , at o'clock M., in the records of said County, in volume , on pages

WITNESS MY HAND AND SEAL OF THE COUNTY COURT of said County, at office in , the day and year last above written.

[L.S.]

County Clerk County, Texas.
By , Deputy.

No.

WARRANTY DEED

With Vendor's Lien

FROM

ADMINISTRATOR OF VETERANS' AFFAIRS

TO

FILED FOR RECORD

This day of
A.D. 19 , at o'clock M.
County Clerk, County, Texas
By , Deputy

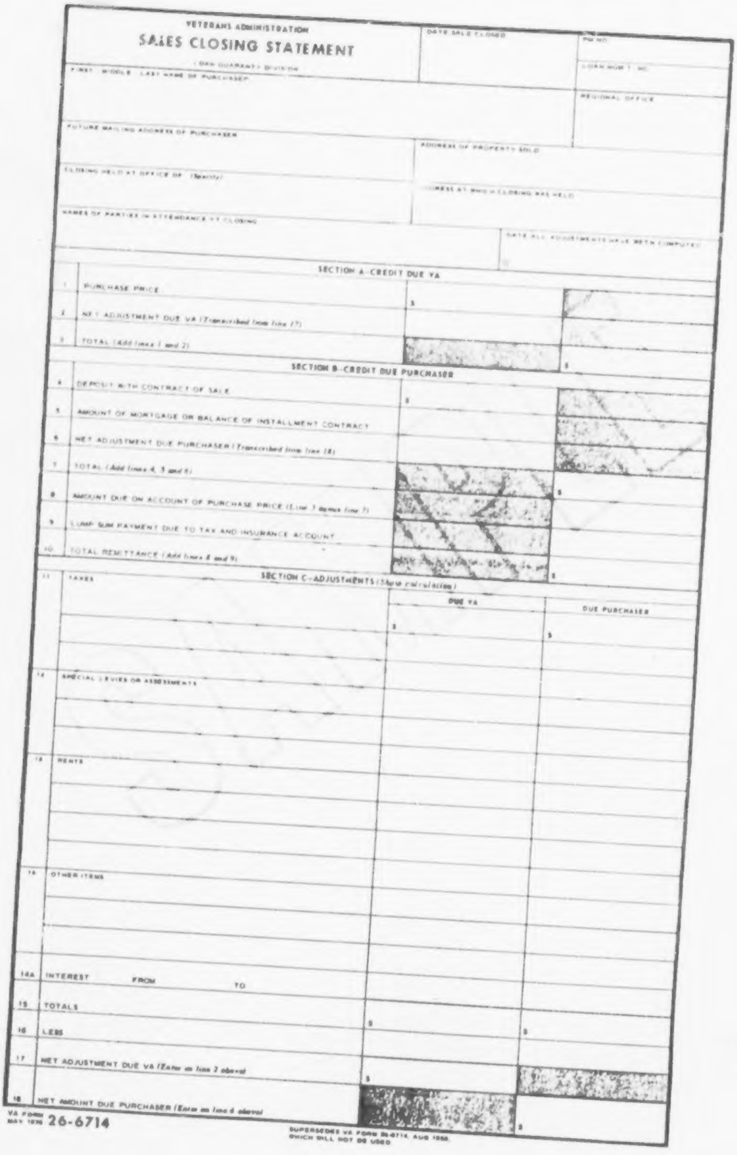
RECORDED

A.D. 19
in county records.
Book , page
County Clerk.
Deputy.

Recording fee, $

This instrument should be filed immediately with the County Clerk for record.

[illegible]



VETERANS ADMINISTRATION

SALES CLOSING STATEMENT

LOAN GUARANTY DIVISION

DATE SALE CLOSED

PM NO.

LOAN NUMBER NO.

FIRST - MIDDLE - LAST NAME OF PURCHASER

REGIONAL OFFICE

FUTURE MAILING ADDRESS OF PURCHASER

ADDRESS OF PROPERTY SOLD

CLOSING HELD AT OFFICE OF (Specify)

ADDRESS AT WHICH CLOSING WAS HELD

NAMES OF PARTIES IN ATTENDANCE AT CLOSING

DATE ALL ADJUSTMENTS HAVE BEEN COMPUTED

SECTION A-CREDIT DUE VA

1	PURCHASE PRICE	$	▨
2	NET ADJUSTMENT DUE VA (Transcribed from line 17)		▨
3	TOTAL (Add lines 1 and 2)	▨	$

SECTION B-CREDIT DUE PURCHASER

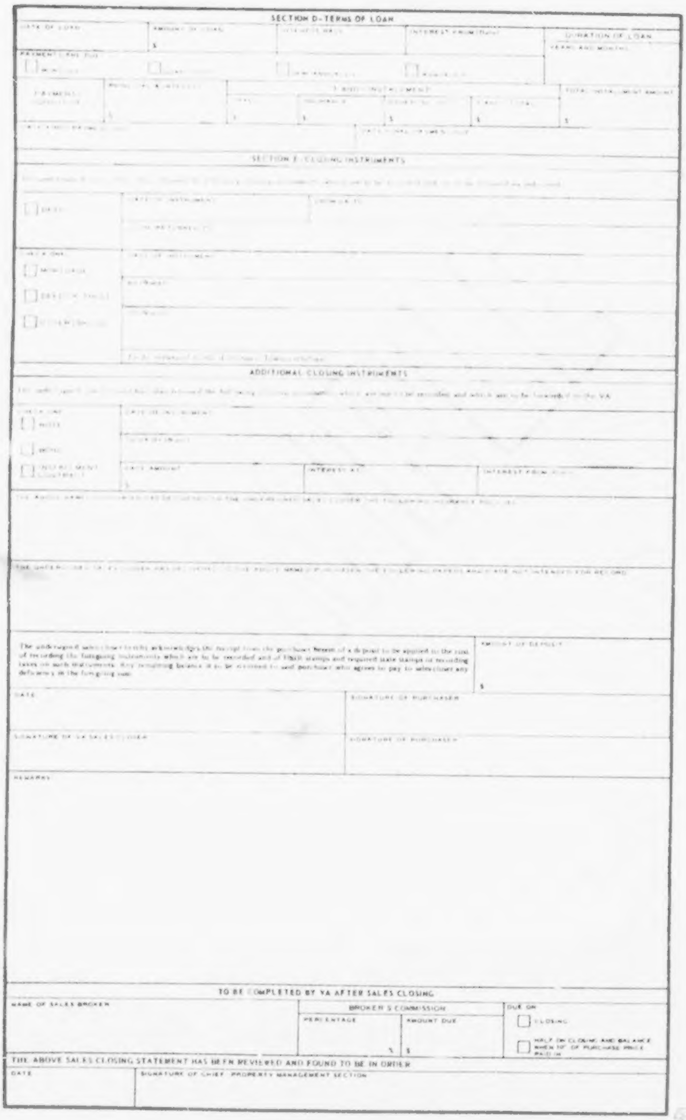
4	DEPOSIT WITH CONTRACT OF SALE	$	▨
5	AMOUNT OF MORTGAGE OR BALANCE OF INSTALLMENT CONTRACT		▨
6	NET ADJUSTMENT DUE PURCHASER (Transcribed from line 18)		▨
7	TOTAL (Add lines 4, 5 and 6)	▨	$
8	AMOUNT DUE ON ACCOUNT OF PURCHASE PRICE (Line 3 minus line 7)	▨	
9	LUMP SUM PAYMENT DUE TO TAX AND INSURANCE ACCOUNT	▨	
10	TOTAL REMITTANCE (Add lines 8 and 9)	▨	$

SECTION C-ADJUSTMENTS (Show calculation)

		DUE VA	DUE PURCHASER
11	TAXES	$	$
12	SPECIAL LEVIES OR ASSESSMENTS		
13	RENTS		
14	OTHER ITEMS		
14A	INTEREST FROM TO		
15	TOTALS		
16	LESS	$	$
17	NET ADJUSTMENT DUE VA (Enter on line 2 above)	$	▨
18	NET AMOUNT DUE PURCHASER (Enter on line 6 above)	▨	$

VA FORM
MAY 1970 26-6714

SUPERSEDES VA FORM 26-6714, AUG 1968,
WHICH WILL NOT BE USED



SECTION D—TERMS OF LOAN

DATE OF LOAN	AMOUNT OF LOAN $	INTEREST RATE	INTEREST FROM (Date)	DURATION OF LOAN YEARS AND MONTHS

PAYMENTS ARE DUE
☐ MONTHLY ☐ QUARTERLY ☐ SEMI-ANNUALLY ☐ ANNUALLY

PAYMENTS [illegible]	PRINCIPAL & INTEREST $	[illegible] INSTALLMENT [illegible] $	[illegible] $	[illegible] $	[illegible] $	TOTAL INSTALLMENT AMOUNT $

DATE FIRST PAYMENT DUE
DATE FINAL PAYMENT DUE

SECTION E—CLOSING INSTRUMENTS

[illegible]

☐ DEED
DATE OF INSTRUMENT
FROM (VA TO)
TO (PURCHASER(S))

CHECK ONE
☐ MORTGAGE
☐ DEED OF TRUST
☐ OTHER (Specify)
DATE OF INSTRUMENT
IN FAVOR OF
[illegible]
[illegible]

ADDITIONAL CLOSING INSTRUMENTS

[illegible] which are not to be recorded and which are to be forwarded to the VA

CHECK ONE
☐ NOTE
☐ BOND
☐ INSTALLMENT CONTRACT
DATE OF INSTRUMENT
IN FAVOR OF
FACE AMOUNT $
INTEREST AT
INTEREST FROM (Date)

THE ABOVE NAMED [illegible] THE FOLLOWING INSURANCE POLICIES

THE UNDERSIGNED SALES CLOSER HAS DELIVERED TO THE ABOVE NAMED PURCHASER THE FOLLOWING PAPERS WHICH ARE NOT INTENDED FOR RECORD

The undersigned sales closer hereby acknowledges the receipt from the purchaser herein of a deposit to be applied to the cost of recording the foregoing instruments which are to be recorded and of [illegible] stamps and required state stamps or recording taxes on such instruments. Any remaining balance is to be returned to said purchaser who agrees to pay to sales closer any deficiency in the foregoing sum.

AMOUNT OF DEPOSIT
$

DATE
SIGNATURE OF PURCHASER
SIGNATURE OF VA SALES CLOSER
SIGNATURE OF PURCHASER

REMARKS

TO BE COMPLETED BY VA AFTER SALES CLOSING

NAME OF SALES BROKER	BROKER'S COMMISSION		DUE ON
	PERCENTAGE %	AMOUNT DUE $	☐ CLOSING ☐ HALF ON CLOSING AND BALANCE WHEN 10% OF PURCHASE PRICE PAID IN

THE ABOVE SALES CLOSING STATEMENT HAS BEEN REVIEWED AND FOUND TO BE IN ORDER

DATE
SIGNATURE OF CHIEF, PROPERTY MANAGEMENT SECTION

VA AUCTION HIGHLIGHTS

THE VETERANS ADMINISTRATION HOME AUCTION IS BACK! In early 1985, the Houston office of the United States Veterans Administration decided to take an innovative step — to get its many inventoried properties back into the hands of the people quickly — BY AUCTION!

On June 7 and 8, 1985, standing room only crowds of over 1500 people each day were rewarded for their efforts when the Veterans Administration accepted the top bid made on the 175 auction properties! Many first-time homebuyers and first-time investors had their dreams realized!

Today, in 1986, the Houston Regional Veterans Administration office has decided to continue this exciting auction tradition by offering the most single-family homes and condominiums ever sold at one time by auction in U.S. history: 250 Properties!! You are urged to view the properties, make your estimate of their worth, and come buy them at **The Great VA Home Auction** which will take place Saturday and Sunday, February 8-9, 1986 at the Westin Galleria Hotel, 5060 W. Alabama, Houston, TX.

SEE YOU AT THE AUCTION!!

OPEN HOUSE SCHEDULE

SATURDAY, FEBRUARY 1 — 10:00 a.m. - 6:00 p.m.
Anahauc, Channelview, Cleveland, Conroe, Hitchcock, Magnolia, Montgomery, Navasota, Needville, Richmond
Key Numbers: 150-334, 657-661

SUNDAY, FEBRUARY 2 — 10:00 a.m. - 6:00 p.m.
Key Numbers: 368-373; 406-413; 446-451

MONDAY, FEBRUARY 3 — 12:00 noon - 6:00 p.m.
Key Numbers: 374-379; 414-419; 452-456

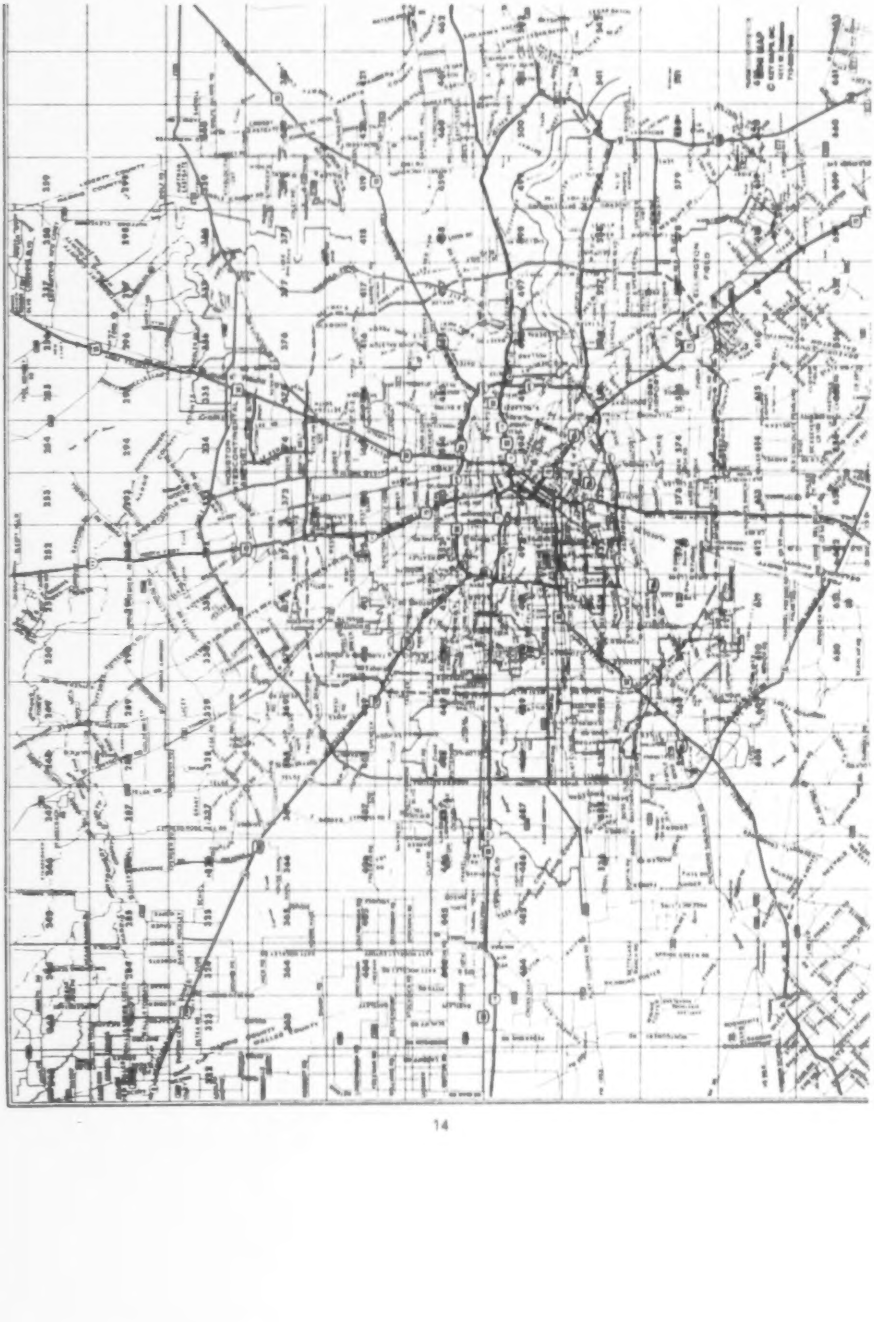
TUESDAY, FEBRUARY 4 — 12:00 noon - 6:00 p.m.
Key Numbers: 457-459; 494-499; 534

WEDNESDAY, FEBRUARY 5 — 12:00 noon - 6:00 p.m.
Key Numbers: 535-540; 535-579; 615-619

THURSDAY, FEBRUARY 6 — 12:00 noon - 6:00 p.m.
Key Numbers: 533; 571-574; 611-614

FRIDAY, FEBRUARY 7 — 12:00 noon - 6:00 p.m.
Key Numbers: 488-493; 537-532; 569-570; 610

HOUSTON AUCTION KEY MAP



HOMES TO BE AUCTIONED SATURDAY, FEBRUARY 8th — 10 am

[For "Garage" A = Attached, D = Detached, CP = Carport]

Auction Homes (Sat. Feb. 8th)	Subdivision	Rooms	Bedrooms	Bathrooms	Garage	Key Map#
1. 2415 Fairbanks, Houston	Central Garden	5	2	1	1A	454S
2. Rte. 18 Box 601 9G, Conroe	Twin Lakes	3	1	1	no	221/222
3. 21 South Lakeview Dr., Montgomery	Tri-Lakes	5	2	1	no	152F
4. 7313 Gulf Freeway #313, Houston	(Condo)	3	1	1	1CPD	536J
5. 11014 Vailview Dr., Houston	Northwood Manor	4	2	1	no	415S
6. 5675 De Soto #116, Houston	(Condo)	4	1	1	1CPD	451C
7. 5026 Ridgevan, Houston	Ridgemont (Tnhm)	4	2	1	no	611C
8. 6514 Linden, Houston	Enfield Addition	7	3	1	2D/1CPA	534H
9. 420 Lindale, Houston	Lindale Extension	6	3	1	1D	453Q
10. 4902 Gren, Houston	MacGregor Terrace	4	2	1	1A	534N
11. 6505 Kasserine Pass, Houston	South Park	5	2	1	no	534N
12. 7811 Fuqua, #7811 Houston	(Condo)	5	3	2	2CPD	575T
13. 9842 Lum Lane, Houston	Wood-Glen	6	3	1.5	1A	455D
14. 2114 Highland Shores, Highlands	Highland Shores	7	3	2	1A	459E
15. 8425 Hearth #36, Houston	(Condo)	4	2	2	1CP	532Q
16. 10555 Turtlewood Ct. #2112, Houston	(Condo)	4	2	2	1CPD	529L
17. 6802 Leedale Rd., Houston	Northwood Manor	6	3	1.5	2A	415S
18. 1521 Margaret Dr., Houston	Sunnyland Farms	6	3	1.5	no	413Z
19. 10403 Forum Park Dr. #123, Houston	(Condo)	5	2	2	1CPD	529V
20. 1835 Oriole, League City	Clear Creek Heights	7	3	1	no	658Q
21. 702 Oak Glen, Dr., Houston	Hawthorne Place	5	2	1	1CPA/2A	413U
22. 922 Pennygent Lane, Channelview	Sterling Green South	6	3	2	1A	497D
23. 8324 Wallace, Hitchcock	Townsite	5	3	1	1CPD/1D	no key
24. 11606 Birch Run, Houston	Rushwood	5	2	2	1D	372N
25. 2003 Florida St., Baytown	Britton-Cravens	6	3	1.5	no	540D
26. 15122 Sheffield Terrace, Houston	Sterling Green South	5	2	1	no	497D
27. 509 Shane, Houston	Blue Bell Place	6	3	1	1A	412H
28. 2021 Spenwick Dr. #517, Houston	(Condo)	6	2	2	1CPA	451S
29. 7012 Smith Dr., Hitchcock	Mainland	5	2	1.5	2A	no key
30. 302 S. Logan, Texas City	Park Addition	7	4	3	2CPA	no key
31. 5422 Ridge Wind Lane, Houston	Quail Bridge	5	2	1	no	611C
32. 13138 Nature Trail, Houston	Parkway Forest	5	3	2	2A	457A
33. 6855 Chasewood Dr., Missouri City	Willow Park	4	2	2	2CP	570V
34. 11718 Boxhill Dr., Houston	Northcliffe Manor	3	1	1	1A	371K
35. 14030 Towneway Dr., Sugarland	Townewest	5	2	1	1A	528T
36. 13214 Foxleigh Ct., Houston	Hunterwood Village	6	3	2	1A	456Q
37. 3434 Woodmont Dr., Houston	Glen Iris	5	3	2	1A	572F
38. 2223 Ridge Hollow, Houston	Rushwood	6	3	2	2A	371M
39. 16615 Monte Carlo Ct., Houston	Quail Bridge (½ dup.)	5	3	2	1A	611C
40. 1802 Wren, League City	Clear Creek Heights	6	3	2	2A	658Q
41. 3011 Overcross, Houston	Glen Iris	6	3	2	2A	572F
42. 15515 Rose Ridge Ct., Missouri City	Briargate	5	3	2	2A	571X
43. 14811 Waterside Dr., Houston	Sterling Green Estates	6	3	2	2A	457U
44. 3618 Kennington Ct., Huffman	Idleloch	6	3	2	2A	299S
45. 16514 Espinosa Dr., Houston	Mission West	6	3	1.5	2A	527K
46. 15534 Vonnet, Channelview	Shadow Glen	6	3	2	no	498B
47. 14015 Hollow Pines Ct., Houston	Pine Trails	5	3	2	2A	456R
48. 7427 Maczali Dr., Missouri City	Briargate	6	3	2	2A	571W
49. 11706 Clover Green, Houston	Rush Wood	6	4	2	2A	372J
50. 8335 Shadow Wind Dr., Houston	Windfern Garden	6	3	2	2D	410J
51. 29507 Memorial Dr., Spring	Spring Forest	9	4	2	2A	292D
52. 6707 Ingate, Missouri City	Briargate	6	3	2	2A	571W
53. 2519 Garapan Ave., Houston	Yorkdale Addition	7	3	2.5	1CPA	412W
54. 304 Vincent, Houston	Brooke Smith	9	4	2	no	453Y
55. 16802 Forest Bend Ave., Friendswood	Forest Bend	8	4	2	no	617W
56. 1834 Grand Park Dr., Missouri City	Quail Green West	5	3	1	2A	570W
57. 25022 Barmby Dr., Tomball	Londonderry	8	3	2.5	2A	250W
58. 11218 Sagecanyon, Houston	Sagemont	9	4	2	2D	616A
59. Rte 7 Box 564, Cleveland	—	6	3	2	2D	no key
60. 8515 Bird Run, Missouri City	Quail Glenn	7	3	2.5	2A	610G
61. 11415 Birdwing, Houston	Lincoln Green East	8	3	2	2A	372N
62. 11714 Fallwood, Houston	Meisterwood	7	3	2.5	2D	368Q
63. 2815 Hollow Creek, Houston	Park Hollow Place	7	4	2.5	2A	488Y
64. 14802 Windlea Lane, Houston	Wind Fern Forest	8	3	2	2A	410J
65. 6835 Wellwood Ct., Houston	Breawood Glen	7	5	3	2A	528G

HOMES TO BE AUCTIONED SATURDAY, FEBRUARY 8th (continued)

Auction Homes (Sat., Feb. 8th)		Subdivision	Rooms	Bedrooms	Bathrooms	Garage	Key Maps
66	12010 Meadow Hollow, Stafford	The Meadows	8	4	2	2A	569A
67	6410 Barrygate Dr., Spring	Greengate	8	4	2	2A	334F
68	8338 Autumn Wind Dr., Houston	Windfern Gardens	4	2	2	2CP	410J
69	10719 Swan Glen Dr., Houston	Keegans Glen	7	3	2	2A	529W
70	1111 Grand Park, Missouri City	Hunters Glen	5	3	2	2A	570X
71	7818 Chaseview, Missouri City	Willow Park	6	3	2	2A	570V
72	11434 Brook Meadow Dr., Houston	Wood Meadow	9	3	2.5	2A	616C
73	2306 Gumspring Lane, Spring	North Spring	7	4	2	2A	293T
74	3823 Mattingham Dr., Houston	Northcliffe Manor	6	3	2	2A	371K
75	14814 Selwyn Dr., Houston	Sterling Green	6	3	2	2A	457U
76	10811 Clear Fork Dr., Humble	Timberhills	6	3	2	2A	376T
77	5811 Misty Meadow, League City	Country Side	6	4	2	2A	657U
78	3906 Mattingham Dr., Houston	Northcliffe Manor	5	2	2	1A	371K
79	2009 Sunset Ct. North, League City	Newport	7	3	2	2A	658Q
80	6439 Turtlewood, Houston	Hunterwood Village	5	3	2	2A	456R
81	1426 Somercotes Ln., Channelview	Sterling Green	5	3	2	2A	457Z
82	7607 Breezeway, Houston	Woodland Trails North	6	3	2	2A	410V
83	6531 Langham Way, Houston	North Glen	6	3	2	2A	407T
84	22242 Waynegate Dr., Spring	Greengate Place	6	3	2	1A	334C
85	12618 Day Hollow Ln., Houston	Tallow Wood	5	3	2	2A	369L
86	15231 Hwy 36, Needville	Plainview	7	3	2	no	no key
87	282 Casa Grande, Houston	Green Ridge North	6	3	2	1A	372Z
88	5315 Bungalow, Houston	Crestmont Park	7	3	2	2A	574J
89	12343 Kings Chase Dr., Houston	Kings Lake Forest	4	2	2	1CPA	416L
90	2512 Ironclad Dr., League City	The Landing	4	2	1	1A	658P
91	9602 Riverside Lodge Dr., Houston	Keegans Wd (½ dup)	4	2	1.5	no	528T
92	15110 Sheffield Ter., Channelview	Sterling Green South	7	3	2	1A	497B
93	3315 Woodmont, Houston	Glen Iris	5	3	2	1A	572F
94	12614 Ridgelow Ln., Houston	Tallow Wood	6	3	2	1A	369L
95	28619 Islington Dr., Huffman	Idlenoch	6	3	2	1A	299S
96	7219 Gulf Bank, Houston	Woodland Trails North	5	3	1.5	2A	411N
97	4531 Adonis Dr., Spring	Birnam Wood	5	2	2	2A	333C
98	6518 Cherrydale Dr., Houston	Southview Addition	5	3	1	1A	534U
99	806 Monvil, Navasota	Blackshear Heights	5	3	2	1CP	no key
100	5421 Diane Court, Spring	Postwood	7	3	2	no	334E
101	16536 Gold Ridge Ln., Houston	Quail Bridge	5	2	2	no	611C
102	10031 Ridgecoral, Houston	Ridgepoint	5	2	2	no	412D
103	5675 De Soto Dr., #224, Houston	(Condo)	4	1	1	1CPD	451C
104	15511 Rose Ridge Ct., Missouri City	Briargate	5	3	2	2A	571X
105	713 Evergreen, Porter	—	4	2	1	no	296M
106	9030 Laura Koppe, Houston	Chatwood Place	5	3	1	1D	455H
107	5635 De Soto Dr., #1018, Houston	(Condo)	7	3	2	no	451C
108	9429 Caddo, Houston	Kentshire Place	6	3	1.5	no	455B
109	746 Woodhue, Channelview	Shadowglen	5	3	1	1CPA/1A	498B
110	8421 Hearth #22, Houston	(Condo)	6	2	2	no	532U
111	1011 Forum W. Dr. #433 D, Houston	(Condo)	4	2	1.5	1CPD	529V
112	5806 Southgood, Houston	South Crest	6	2	1	1A	534S
113	7803 Queen St., Houston	Liberty Road Manor	5	2	1	no	455N
114	17701 Meadow Brook Ln., Channelview	San Jacinto River Est.	4	2	1	1A	459X
115	12924 Gladden, Houston	Beaumont Place	5	3	1	no	456M
116	2816 S. Bartell Dr. #311, Houston	(Condo)	3	1	1	1CPD	532Q
117	2147 William Tell, Houston	Westfield Estates	4	2	1	no	413V
118	3110 Stallings Dr., Houston	Garden City Park	4	2	1	1A	411R
119	2928 Sherwick, Houston	Wood Bayou	5	2	1	no	454E
120	2011 Spenwick #320, Houston	(Condo)	2	1	1	1CPD	451S
121	6547 Crestford, Pasadena	Crest Home Estates	5	3	1.5	2D/1CPA	578A
122	5009 Dieppe, Houston	Southpark	4	2	1	1A	534S
123	212 Plaza Verde #18-F, Houston	(Condo)	4	2	1	1CPD	372V
124	5602 Pershing, Houston	Southcrest (Vac Lot)	—	—	—	—	334S
125	Rte. 4 Box 496-A, Conroe	(Vac Lot)	—	—	—	—	219C-220E

HOMES TO BE AUCTIONED SUNDAY, FEBRUARY 9th — 1 PM

Auction Homes (Sun., Feb. 9th)	Subdivision	Rooms	Bedrooms	Bathrooms	Garage	Key Maps
126 10237 Palestine, Houston	Industrial Addition	4	2	1	1CPD	495M
127 1438 D Woodland Rd., Splendora	Woodlane	6	3	1.5	no	194X
128 9112 Kelburn, Houston	Barclay	5	2	1	2D	454H
129 7313 Gulf Freeway #1003, Houston	(Condo)	3	1	1	1CPD	535J
130 5665 De Soto Dr. #325C, Houston	(Condo)	4	2	1	1CPD	451C
131 5126 Ridgeway, Houston	Inwood Terrace	5	3	1	1CPA	534S
132 603 Elk Dr. (Rte. 3), Crosby	Happy Hide-A-Way	5	3	2	no	379A
133 8707 Lanewood, Houston	Laura Kappe Place	5	2	1	no	454H
134 5225 Antha, Houston	North Shadydale Ext	4	2	1	1CP	454C
135 12711 Scott St., Houston	South Acre Estates	6	3	1.5	2D/1CP	573Q
136 10555 Turtlewood Ct. #2516, Houston	Bldg. Y (Condo)	3	1	1	1CPD	529G
137 4825 Burma, Houston	South Park	6	3	1	no	534S
138 1102 Yellowstone River, Montgomery	Lake Conroe First	4	2	1	no	155J
139 7313 Gulf Freeway #709, Houston	(Condo)	3	1	1	1CPD	535J
140 8523 Hearth Dr. #2, Houston	(Condo)	5	3	2	1CPD	532Q
141 14505 Maeline, Houston	Aldine Place	6	3	2	no	373Z
142 7638 Claiborne, Houston	Scenic Woods	6	3	1	1CP	455A
143 1723 Canary Circle, League City	Clear Creek Heights	5	2	1	1CP	658Q
144 10555 Turtlewood Ct. #2802, Houston	(Condo)	4	2	2	1CP	529G
145 4911 Red Fish Reef, Bacliff	Bacliff Villas	7	3	1	no	661N
146 510 Gober, Houston	Oak Meadows	5	3	1	1A	535M
147 13103 Nature Trail, Houston	Parkway Forest	4	2	1	1A	457J
148 1012 Leake St., Navasota	—	5	3	1	no	no key
149 7006 Maczak Dr., Missouri City	Briargate	6	3	2	2A	571W
150 16914 Folsom Dr., Houston	Sheldon Woods	6	3	2	2A	458A
151 3110 Cliff Swallow, Spring	Timber Lane	4	2	1.5	1A	333B
152 1507 Birch Bend Circle, Houston	Rushwood	5	3	1	1A	372N
153 16531 Goldridge Ln., Houston	Goldridge	5	2	1	no	611C
154 6622 New World Dr., Katy	Settlers Village	5	2	2	2A	406T
155 3219 Brookston, Houston	Glen Iris	6	3	1.5	no	572F
156 4629 Market; 1303,5,7 Schweikardt	Pinecrest Court	5/6/6	3/2/2	1/2/2	no	494B
157 15114 Fourwinds, Missouri City	Willow Park	6	3	2	2A	571S
158 16604 Gold Ridge Ln., Houston	Quail Bridge	5	2	1	no	611B
159 19435 Lazy Valley Dr., Katy	Silvermill	6	3	2	no	446R
160 12300 Brookglade Circle #96, Houston	Newleaf Place	5	2	2.5	2D	529N
161 1519 W. Gulf Bank, Houston	Willow Run	6	3	1.5	2CPA	412P
162 6639 Indian Falls, Missouri City	Briargate	7	4	2	no	571W
163 8618 Valley Ledge, Houston	Parkwood East	6	3	2	2A	456B
164 10026 Lasaber Ct., Houston	Ridgepoint	7	3	2	1A	412B
165 9107 Barton Ave., Houston	Easthaven	5	3	1	1D	575H
166 3535 Spanish Acorn Ln., Spring	Forest North	6	3	2	2A	291L
167 14211 Dartwood, Houston	Pine Trails	5	3	2	2A	456R
168 3206 Abbey Field Ln., Porter	Country Colony	7	3	2	2A	297J
169 17726 Autumn Trail Lane, Houston	North Glen	6	3	2	2A	407P
170 34 Forest Lane, Conroe	Woodland Forest	8	4	2	no	221Y
171 10555 Turtlewood Ct. #1205, Houston	Bldg. L (Condo)	4	2	2	1CPD	529G
172 602 Pixie Dr., League City	The Landing	5	3	2	2A	658P
173 11722 Old Telegraph Rd., Houston	Rushwood	7	4	2	2A	371R
174 15834 Rosebriar Dr., Missouri City	Briargate	6	4	2	2A	570Z
175 16234 Corsair, Houston	Ridgegate	5	2	2	1A	611B
176 13431 Wimbledon Oaks Dr., Houston	Oak Cliff Place	6	3	2	2A	368Y
177 13843 Rosetta, Cypress	Bonaire	6	3	2	2A	368T
178 7938 Glen Vista, Houston	Glenbrook Valley	8	4	2	1CP	535X
179 2900 Dunrich Ct., League City	Bayridge	6	3	2	2A	660J
180 8330 Autumn Wind Dr., Houston	Windfern Gardens	5	2	2	2CP	410J
181 8307 Bee Meadow, Missouri City	Quail Glen	6	3	2	2A	610G
182 8215 Quail Hills Dr., Missouri City	Quail Run	6	4	2	2A	610C
183 17019 Cairntosh, Houston	Glencairn Village	6	3	2	2A	447G
184 2018 Summer Place Dr., Missouri City	Quail Green West	5	3	2	2A	570W
185 9902 Crescent Moon, Houston	Harvest Bend	7	3	2	2A	369V

HOMES TO BE AUCTIONED SUNDAY, FEBRUARY 9th (continued)

Auction Homes (Sun., Feb. 9th)		Subdivision	Rooms	Bedrooms	Bathrooms	Garage	Key Map
186	15714 Ironside Cr. Dr., Missouri City	Ridgegate	6	3	2	2A	571X
187	16010 Cerca Blanca, Houston	Mission Bend	8	3	2	2A	527L
188	3715 Golden Lake, Kingwood	Greentree Village	8	4	2	2D	297T
189	11602 S. Oak Ct., Houston	Southbend	8	3	2.5	2A	616G
190	16210 North Trial Dr., Houston	Northview	6	3	2	2A	332U
191	11311 Mullholland, Stafford	Meadow Village	6	2	2	2A	529W
192	11039 Hidden Bend Dr., Houston	Harvest Bend	7	3	2	2A	369Y
193	2226 Gray Hawk Dr., Katy	Sundown	6	3	2	2A	446T
194	10554 Hammerly, Houston	Victorian Vill. (Tnhn)	6	3	2.5	2CP	449R
195	518 William Morton Dr., Richmond	Pecan Grove	7	4	2	2A	no key
196	17335 Edgehaven Dr., Missouri City	Quail Glen	5	3	2	2A	610G
197	8334 Windy Oaks Dr., Houston	Windfern Gardens	5	2	2	2CP	410J
198	10734 Kentington Oak Dr., Humble	Timberhills	5	3	2	2A	376T
199	3315 Creek Grove, Houston	Briarcreek	6	3	2	2A	371U
200	7502 Kite Hill Dr., Houston	Chimney Hill	5	3	2	2A	408Q
201	2502 Harpers Ferry, League City	The Landing	6	3	2	2A	658P
202	10006 Carlow, LaPorte	Fairmont Park West	6	4	2	2A	579A
203	14614 Lourdes, Houston	Pinetrails	6	3	2	2A	457S
204	2829 21st Ave. North, Texas City	Westbury	7	3	2	2A	no key
205	11746 Apple Bough Cir., Houston	Rushwood	6	4	2	2A	372J
206	6647 West Fuqua Dr., Missouri City	Briargate	6	3	2	2A	571W
207	12319 Kingslake Forest, Houston	Kings Lake Forest	6	4	2	2A	416L
208	14146 Flair, Houston	Pine Trails	6	3	2	2A	456V
209	1454 Willersley Lane, Channelview	Sterling Green	7	4	2	2A	457Z
210	4627 Oakside, Houston	Westbrook	8	3	2	2CP	571V
211	1828 Eagle, League City	Clear Creek Heights	5	3	2	2A	658Q
212	7619 Log Cradle Dr., Houston	Chimney Hill	6	3	2	2A	408R
213	7835 Terra Cotta, Houston	Courtyard Homes	5	1	1	1A	410L
214	9206 Goodmeadow Dr., Houston	Harvest Bend	5	3	1.5	1A	369U
215	1803 Bugle Run, Katy	Parkway West	5	2	2	1A	446W
216	5417 Ridge Wind Ln., Houston	Quail Bridge	4	2	1	no	611B
217	11807 Westwold, Tomball	Westbourne	6	3	2	2A	328H
218	4923 Porter Ridge, Houston	Ridgemont	5	3	2	1A	611C
219	3230 Lucida Lane, Spring	Timberlane	5	2	1.5	1A	293X
220	5138 Ravenridge, Houston	Ridgemont	6	3	2	2A	611C
221	714 Armor, Pasadena	Shaver Place	5	3	1	1A	536V
222	9019 Berwyn, Houston	Northline Terrace	5	3	1.5	1A	412M
223	4111 Grapevine, Houston	South Glen	6	3	2	2A	572N
224	Rte. 2 Box 2780, Conroe	—	6	3	1	no	no key
225	6147 Beldart, Houston	Belfort	8	4	1	1CPA	534Y
226	1450 Dogwood Ln., Splendora	Woudlane	6	2	1.5	no	195W
227	6518 Flamingo, Houston	Overbrook Addition	8	3	1	no	534Y
228	8323 Wilcrest #10014	(Condo)	4	2	1.5	1CPD	529Q
229	329 E. Wilkins, League City	Clear Creek	8	3	1	no	659J
230	604 Pemberton, Channelview	Channelview Acres	5	2	1	no	498G
231	5338 Bataan, Houston	South Park	6	3	2	2D/1CPA	534N
232	10202 Forum Park Dr. #249, Houston	(Condo)	4	2	2	1CPD	529V
233	210 Easy St., Magnolia	Woodland Lakes	4	2	1	no	211X
234	8018 Lynette, Houston	Clairmont Place	6	3	1	1A	455F
235	5675 De Soto Dr. #220, Houston	(Condo)	5	2	2	1CPD	451C
236	8026 Winthrop, Houston	Skyscrape Shadow	6	3	1	1CP	575K
237	7313 Gulf Freeway 1005, Houston	Bldg. J (Condo)	4	2	1	1CPD	535J
238	8922 Caddo, Houston	Kentshire Place	6	3	1	1CP	455D
239	10403 Forum Park Dr. #335, Houston	(Condo)	3	1	1	1CPD	529V
240	709 Beaumont, Anahauc	Wilcox Addition	5	2	1	1CP	no key
241	7995 Cinderella, Houston	Liberty Road Manor	4	2	1	no	455T
242	5831 Grace Ln., Houston	Griggs Terrace	5	2	1	no	534J
243	4410 Gaston, Houston	N. Houston Heights	4	2	1	no	414Q
244	144 Grothe, Houston	Peter Janowski	4	1	1	2D	453F
245	212 Plaza Verde Dr. #24 F, Houston	(Condo)	4	2	1.5	1CPD	372V
246	1921 Warwick, Houston	Westfield Estates	6	3	1	no	413R
247	212 Plaza Verde #F16, Houston	(Condo)	4	2	1	1CP	372V
248	36 Liberty Creek, Cleveland	Liberty Cr.	5	3	1	no	164L
249	2514 Creston, Houston	Creston Place	8	3	1	no	454N
250	5135 Dogwood Ln., Conroe	Lake Wildwood	Vac Lot	—	—	—	no key

HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

HOUSE NO. 1 - Key Map #454S
Address: 2415 Fairbanks | PM#420970
City: Houston | Zip: 77086 | Lot Size: 50x100
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 1

HOUSE NO. 2
Address: Rt. 18, Box 601GG | PM#4-26228
City: Conroe | Zip: 77302 | Lot Size: 120x300
Rms: 3 | Bdrms: 1 | Baths: 1 | Gar: 0

HOUSE NO. 3 - Key Map #152F
Address: 21 South Lake Dr | PM#2-425985
City: Montgomery | Zip: 77356 | Lot Size: 60x150
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 4 - Key Map #535J
Address: 7313 Gulf Freeway #313 PM #2-517626
City: Houston | Zip: 77017 | Lot Size: Condo
Rms: 3 | Bdrms: 1 | Baths: 1 | Gar: 1CP

HOUSE NO. 5 - Key Map #415S
Address: 11014 Vailview Dr | PM#2-525160
City: Houston | Zip: 77016 | Lot Size: 50x110
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 6 - Key Map #451C
Address: 5675 DeSoto #116 | PM #2-514467
City: Houston | Zip: 77091 | Lot Size: Condo
Rms: 4 | Bdrms: 1 | Baths: 1 | Gar: 1CP

HOUSE NO. 7 - Key Map #661C
Address: 5026 Ridgevan | PM #574060
City: Houston | Zip: 77053 | Lot Sz: 21.88x109.15
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 8 - Key Map #534H
Address: 6514 Linden | PM#2-454224
City: Houston | Zip: 77087 | Lot Size: 65x115
Rms: 7 | Bdrms: 3 | Baths: 1 | Gar: 2

HOUSE NO. 9 - Key Map #453Q
Address: 420 Linden
City: Houston | Zip: 77087
Rms: 6 | Bdrms: 3 | Baths: 1 | Gar: 1

HOUSE NO. 10 - Key Map #534N
Address: 4902 Gren | PM #2-543623
City: Houston | Zip: 77021 | Lot Size: 60x110
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1

HOUSE NO. 11 - Key Map #534N
Address: 5505 Ressering Pass | PM#2-501317
City: Houston | Zip: 77033 | Lot Size: 51.6x110
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 12 - Key Map #575T
Address: 7811 Fuqua | PM #2-494876
City: Houston | Zip: 77075 | Lot Size: Condo
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2CP

HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

HOUSE NO. 13 - Key Map #455D
Address: 9842 Lum Lane | PM#4-24106
City: Houston | Zip: 77078 | Lot Size: 60x105
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: 1

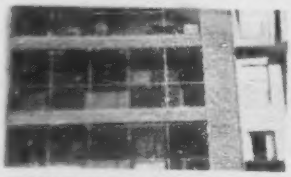
HOUSE NO. 14 - Key Map #459E
Address: 2114 Highland Shores | PM #2-544471
City: Highlands | Zip: 77562 | Lot Size: 70x109
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSE NO. 15 - Key Map #532Q
Address: 8425 Hearth #36 | PM #2453183
City: Houston | Zip: 77054 | Lot Size: Condo
Rms: 4 | Bdrms: 2 | Baths: 2 | Gar: 1CP

HOUSE NO. 16 - Key Map #529L
10555 Turtlewood Ct. #2112 | PM #2552357
City: Houston | Zip: 77072 | Lot Size: Condo
Rms: 4 | Bdrms: 2 | Baths: 2 | Gar: 1CP

HOUSE NO. 17 - Key Map #415S
Address: 6802 Leedale Rd | PM #2-495580
City: Houston | Zip: 77016 | Lot Size: 60x105
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: 2

HOUSE NO. 18 - Key Map #413Z
Address: 1521 Margaret Dr | PM#2-525343
City: Houston | Zip: 77093 | Lot Size: 50x100
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: 0



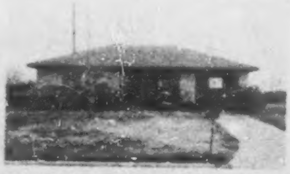
HOUSE NO. 19 - Key Map #529V
Add: 10403 Forum Park Dr. #123 | PM #2-492580
City: Houston | Zip: 77036 | Lot Size: Condo
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 1CP

HOUSE NO. 20 - Key Map #658Q
Address: 1835 Oriole | PM#2-537951
City: League City | Zip: 77573 | Lot Size: 50x100
Rms: 7 | Bdrms: 3 | Baths: 1 | Gar: 0

HOUSE NO. 21 - Key Map #413U
Address: 702 Oak Glenn Dr | PM#2-477803
City: Houston | Zip: 77076 | Lot Size: 65x110
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 2, 1CP

HOUSE NO. 22
Address: 922 Pennygent Ln. | PM#2-525598
City: Channelview | Zip: 77530 | Lot Sz: 59.5x105
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSE NO. 23
Address: 8324 Wallace | PM #2-568533
City: Hitchcock | Zip: 77563 | Lot Size: 50x100
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 1CP



HOUSE NO. 24 - Key Map #372N
Address: 11606 Birch Run | PM#2-538087
City: Houston | Zip: 77067 | Lot Size: 60x110
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 1

HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

HOUSE NO. 25 - Key Map #540D
Address: 2003 Florida St. PM#2-537907
City: Baytown | Zip: 77520 | Lot Size: 70x125
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: 0

HOUSE NO. 26 - Key Map #497D
Address: 15122 Sheffield Terr. PM#2-524829
City: Houston | Zip: 77015 | Lot Size: 60x105
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 27 - Key Map #412H
Address: 509 Shane PM#2-502438
City: Houston | Zip: 77037 | Lot Size: 75x195
Rms: 6 | Bdrms: 3 | Baths: 1 | Gar: 1

HOUSE NO. 28 - Key Map #451S
Address: 2021 Spenwick Dr. #517 PM #2-539256
City: Houston | Zip: 77055 | Lot Size: Condo
Rms: 6 | Bdrms: 2 | Baths: 2 | Gar: 1CP

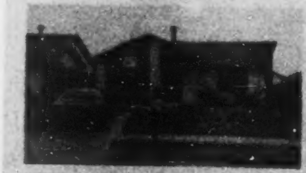
HOUSE NO. 29
Address: 7012 Smith Dr. PM#2-514705
City: Hitchcock | Zip: 77563 | Lot Size: 112x150
Rms: 5 | Bdrms: 2 | Baths: 1½ | Gar: 2

HOUSE NO. 30
Address: 302 S. Logan PM#2-501607
City: Texas City | Zip: 77590 | Lot Size: 70x130
Rms: 7 | Bdrms: 4 | Baths: 3 | Gar: 2CP

HOUSE NO. 31 - Key Map #611C
Address: 5422 Ridge Wind Lane PM #539737
City: Houston | Zip: 77053 | Lot Size: Irreg.
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 32 - Key Map #457A
Address: 13138 Nature Trail PM #2-540232
City: Houston | Zip: 77047 | Lot Size: 60x110
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 33 - Key Map #570V
Address: 6855 Chasewood Dr. PM#2-433748
City: Missouri City | Zip: 77459 | Lot Size: 38x55
Rms: 4 | Bdrms: 2 | Baths: 2 | Gar: 2CP



HOUSE NO. 34 - Key Map #371K
Address: 11718 Borhill Dr. PM #549209
City: Houston | Zip: 77066 | Lot Size: 45x120
Rms: 3 | Bdrms: 1 | Baths: 1 | Gar: 1

HOUSE NO. 35 - Key Map #528T
Address: 14030 Towneway Dr. PM#2-523047
City: Sugarland | Zip: 77478 | Lot Size: 65x115
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 1

HOUSE NO. 36 - Key Map #456Q
Address: 13214 Paxleigh Court PM #2-549303
City: Houston | Zip: 77049 | Lot Size: 45x105
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

HOUSE NO. 37 · Key Map #572Z
Address: 3434 Woodmont Dr. PM#2-524030
City: Houston | Zip: 77045 | Lot Size: 52x105
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSE NO. 38 · Key Map #371M
Address: 2223 Ridge Hollow PM #2-502108
City: Houston | Zip: 77067 | Lot Size: 55x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 39 · Key Map #611C
Address: 16615 Monte Carlo Ct. PM #2-543425
City: Houston | Zip: 77053 | Lot Size: ½ Dup.
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSE NO. 40 · Key Map #658Q
Address: 1809 Wren PM#2-519473
City: League City | Zip: 77573 | Lot Size: 70x112
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 41 · Key Map #572F
Address: 3011 Overcross PM #2-544873
City: Houston | Zip: 77045 | Lot Size: 52x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 42 · Key Map #471X
Address: 15515 Rose Ridge Ct. PM#4-2593
City: Missouri City | Zip: 77459
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 43 · Key Map #457U
Address: 14811 Waterside Dr. PM #2-551567
City: Houston | Zip: 77015 | Lot Size: 70x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 44 · Key Map #2995
Address: 3618 Kennington Ct. PM#4-26453
City: Huffman | Zip: 77336 | Lot Size: 60x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 45 · Key Map #527K
Address: 16514 Espinosa Dr. PM#2-524793
City: Houston | Zip: 77083 | Lot Size: 50x115
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: 2

HOUSE NO. 46 · Key Map #498B
Address: 15534 Vonnet PM#2-536903
City: Channelview | Zip: 77530 | Lot Size: 110x60
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 0

HOUSE NO. 47 · Key Map #456R
Address: 14015 Hollow Pines Ct. PM#2-480599
City: Houston | Zip: 77049 | Lot Size: 100x125
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 48 · Key Map #571W
Address: 7489 Maczali Dr. PM#2-501638
City: Missouri City | Zip: 77459 | Lot Size: 65x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

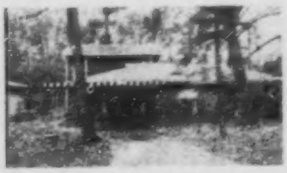
HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

HOUSE NO. 49 - Key Map #378J
Address: 11706 CLover Green PM#2-538491
City: Houston | Zip: 77067 | Lot Size: Irreg.
Rms: 6 | Bdrms: 4 | Baths: 2 | Gar: 2

HOUSE NO. 50 - Key Map #410J
Address: 8335 Shadow Wind Dr PM#2-493837
City: Houston | Zip: 77040 | Lot Size: 60x87.5
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 51 - Key Map #292D
Address: 29507 Memorial Dr PM#2-389439
City: Spring | Zip: 77373 | Lot Size: 65x100
Rms: 9 | Bdrms: 4 | Baths: 2 | Gar: 2

HOUSE NO. 52 - Key Map #571W
Address: 6707 Trigate PM#4-26280
City: Missouri City | Zip: 77489 | Lot Size: 698x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2



HOUSE NO. 53 - Key Map #412W
Address: 2519 Garapan Ave PM#2-477805
City: Houston | Zip: 77091 | Lot Size: 70x105
Rms: 7 | Bdrms: 3 | Baths: 2½ | Gar: 1CP

HOUSE NO. 54 - Key Map #453Y
Address: 304 Vincent PM#2-516821
City: Houston | Zip: 77009 | Lot Size: 50x100
Rms: 9 | Bdrms: 4 | Baths: 2 | Gar: 0

HOUSE NO. 55 - Key Map #617W
Address: 16802 Forest Bend Ave PM#2-453834
City: Friendswood | Zip: 77546 | Lot Size: 65x130
Rms: 8 | Bdrms: 4 | Baths: 2 | Gar: 0

HOUSE NO. 56 - Key Map #570W
Address: 1834 Grand Park Dr. PM#2-522710
City: Missouri City | Zip: 77489 | Lot Size: 60x110
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 2

HOUSE NO. 57 - Key Map #250W
Address: 25099 Bermby Dr. PM#2-517330
City: Tomball | Zip: 77375 | Lot Size: 65x115
Rms: 8 | Bdrms: 3 | Baths: 2½ | Gar: 2

HOUSE NO. 58 - Key Map #616A
Address: 11918 Sagecanyon PM#2-405912
City: Houston | Zip: 77089 | Lot Size: 60x120
Rms: 9 | Bdrms: 4 | Baths: 2 | Gar: 2

HOUSE NO. 59
Address: Rt. 7, Box 564 PM#2-519106
City: Cleveland | Zip: 77327 | Lot Size: 200x217
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

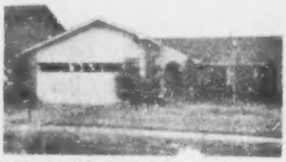
HOUSE NO. 60 - Key Map #611G
Address: 8515 Bird Run PM#2-501689
City: MoCity | Zip: 77459 | Lot Size: 60x115
Rms: 7 | Bdrms: 3 | Baths: 2½ | Gar: 2

HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

HOUSE NO. 61 - Key Map #379N
Address: 11415 Birdwing PM#2-449797
City: Houston Zip: 77067 Lot Size: 152x157
Rms: 8 Bdrms: 3 Baths: 2 Gar: 2

HOUSE NO. 62 - Key Map #368G
Address: 11714 Fallwood PM#2-492604
City: Houston Zip: 77065 Lot Size: 60x110
Rms: 7 Bdrms: 3 Baths: 2½ Gar: 2

HOUSE NO. 63 - Key Map #488Y
Address: 9815 Hollow Creek PM#2-524505
City: Houston Zip: 77082 Lot Size: 64x112.5
Rms: 7 Bdrms: 4 Baths: 2½ Gar: 2



HOUSE NO. 64 - Key Map #410J
Address: 14802 Windlea Lane PM#2-498262
City: Houston Zip: 77040 Lot Size: 55.9x104.16
Rms: 6 Bdrms: 3 Baths: 2 Gar: 2

HOUSE NO. 65 - Key Map #528G
Address: 6835 Wellwood Ct. PM #2-540906
City: Houston Zip: 77083 Lot Size: 60x103
Rms: 7 Bdrms: 5 Baths: 3 Gar: 2

HOUSE NO. 66 - Key Map #569A
Address: 12010 Meadow Hollow PM #2-569578
City: Stafford Zip: 77477 Lot Size: 65x110
Rms: 8 Bdrms: 4 Baths: 2 Gar: 2

HOUSE NO. 67 - Key Map #334F
Address: 6410 Barrygate Dr. PM#2-592021
City: Spring Zip: 77373 Lot Size: 65x115
Rms: 8 Bdrms: 4 Baths: 2 Gar: 2

HOUSE NO. 68 - Key Map #410J
Address: 8338 Autumn Wind Dr. PM#2-518834
City: Houston Zip: 77040 Lot Size: 68x102
Rms: 4 Bdrms: 2 Baths: 2 Gar: 2CP

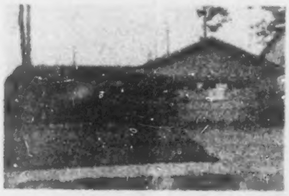
HOUSE NO. 69 - Key Map #529W
Address: 10719 Swan Glen Dr. PM#2-522126
City: Houston Zip: 77083 Lot Size: 55.2x110
Rms: 7 Bdrms: 3 Baths: 2 Gar: 2

HOUSE NO. 70 - Key Map #570X
Address: 1111 Grand Park PM#2-522071
City: Missouri City Zip: 77489 Lot Size: Irreg
Rms: 5 Bdrms: 3 Baths: 2 Gar: 2

HOUSE NO. 71 - Key Map #570V
Address: 7818 Chaseview PM#2-501412
City: Missouri City Zip: 77459 Lot Size: 70x130
Rms: 6 Bdrms: 3 Baths: 2 Gar: 2

HOUSE NO. 72 - Key Map #616C
Address: 11434 Brook Meadow Dr. PM#2-515987
City: Houston Zip: 77089 Lot Size: Irreg
Rms: 9 Bdrms: 3 Baths: 2½ Gar: 2

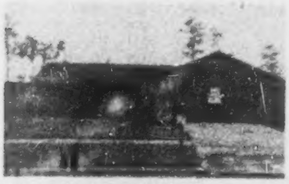
HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986



HOUSE NO. 73 · Key Map #293T
Address 2306 Gum Spring Lane PM#2-472443
City Spring | Zip 77373 | Lot Size 55x110
Rms 7 | Bdrms 4 | Baths 2 | Gar 2

HOUSE NO. 74 · Key Map #371K
Address 3823 Mattingham Dr PM #2-566043
City Houston | Zip 77066 | Lot Size 60x105
Rms 6 | Bdrms 3 | Baths 2 | Gar 2

HOUSE NO. 75 · Key Map #457U
Address 14814 Selwyn Dr PM#2-534583
City Houston | Zip 77015 | Lot Size 63x105
Rms 6 | Bdrms 3 | Baths 2 | Gar 2



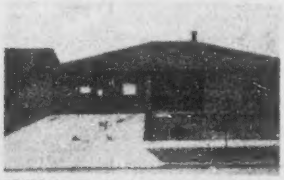
HOUSE NO. 76 · Key Map #376T
Address 10811 Clear Fork Dr PM#2-583095
City Humble | Zip 77338 | Lot Size 60x105
Rms 6 | Bdrms 3 | Baths 2 | Gar 2

HOUSE NO. 77 · Key Map #657U
Address 5811 Misty Meadow PM#2-516697
City League City | Zip 77573 | Lot Size 60x110
Rms 6 | Bdrms 4 | Baths 2 | Gar 2

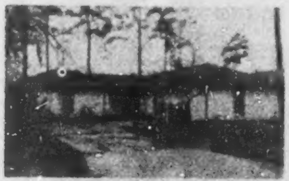
HOUSE NO. 78 · Key Map #371K
Address 3906 Mattingham Dr PM #2-549289
City Houston | Zip 77066 | Lot Size —
Rms 5 | Bdrms 2 | Baths 2 | Gar 1

HOUSE NO. 79 · Key Map #658Q
Address 2009 Sunset Ct. North PM#2-413080
City League City | Zip 77573 | Lot Size 60x110
Rms 7 | Bdrms 3 | Baths 2 | Gar 2

HOUSE NO. 80 · Key Map #456R
Address 6439 Turtlewood PM#2-540649
City Houston | Zip 77013 | Lot Size 64x184
Rms 5 | Bdrms 3 | Baths 2 | Gar 2

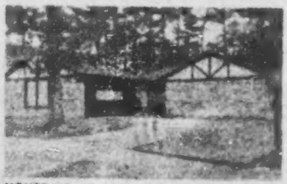


HOUSE NO. 81 · Key Map #457Z
Address 1426 Somercotes Ln PM #2-540649
City Channelview | Zip 77530 | Lot Size 60x105
Rms 5 | Bdrms 3 | Baths 2 | Gar 2



HOUSE NO. 82 · Key Map #410V
Address: 7607 Breezeway PM #2-553530
City: Houston | Zip: 77040 | Lot Size: 62x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 83 · Key Map #407T
Address: 6531 Langham Way PM#2-520569
City: Houston | Zip: 7084 | Lot Size: 50x100
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2



HOUSE NO. 84 · Key Map #334C
Address: 22242 Waynegate Dr. PM#2-538693
City: Spring | Zip: 77373 | Lot Size: 76x105
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

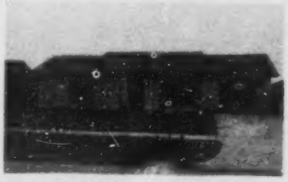
HOUSE NO. 85 · Key Map #369L
Address: 12618 Day Hollow Ln · PM #2-574691
City: Houston | Zip: 77070 | Lot Size: 55x125
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 86
Address: 15231 Hwy 36 · PM#4-26416
City: Needville | Zip: 77461 | Lot Size: 90x195
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 0

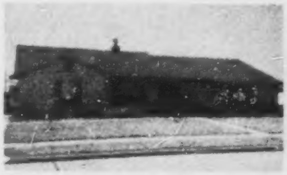
HOUSE NO. 87 · Key Map #372Z
Address: 282 Casa Grande · PM #2-540818
City: Houston | Zip: 77060 | Lot Size: 55x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSE NO. 88 · Key Map #574J
Address: 5315 Bungalow · PM#2-472837
City: Houston | Zip: 77048 | Lot Size: 60x110
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 89 · Key Map #416L
Address: 12343 Kings Chase Dr · PM#2-538793
City: Houston | Zip: 77044 | Lot Size: 60x105
Rms: 4 | Bdrms: 2 | Baths: 2 | Gar: 1CP



HOUSE NO. 90 · Key Map #658P
Address: 2512 Ironclad Dr · PM #2-545489
City: League City | Zip: 77573 | Lot Size: 65x125
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1

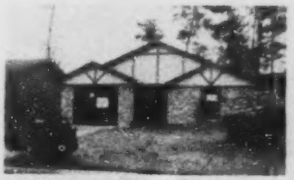


HOUSE NO. 91 · Key Map #528T
Address: 9602 Riverside Lodge Dr · PM#2-539714
City: Houston | Zip: 77093 | Lot Size: 45x115
Rms: 4 | Bdrms: 2 | Baths: 1½ | Gar: 0

HOUSE NO. 92 · Key Map #497B
Address: 15110 Sheffield Ter · PM#2-26850
City: Channelview | Zip: 77530 | Lot Size: 40x110
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSE NO. 93 · Key Map #572F
Address: 3315 Woodmont · PM#2-521560
City: Houston | Zip: 77045 | Lot Size: 50x104
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSE NO. 94 · Key Map #369L
Address: 12614 Ridgelow Ln · PM #2-540248
City: Houston | Zip: 77070 | Lot Size: 45x125
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 1



HOUSE NO. 95 · Key Map #299S
Address: 28619 Islington Dr · PM#2-433067
City: Huffman | Zip: 77336 | Lot Size: 55x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSE NO. 96 · Key Map #411N
Address: 7219 Gulf Bank · PM#2-501983
City: Houston | Zip: 77040 | Lot Size: 60x100
Rms: 5 | Bdrms: 3 | Baths: 1½ | Gar: 2

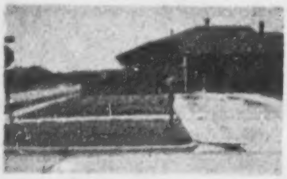
HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

HOUSE NO. 97 - Key Map #333C
Address: 4531 Adonis Dr. PM#2-579925
City: Spring | Zip: 77373 | Lot Size: 60x110
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 2

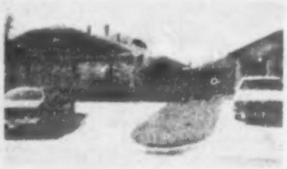
HOUSE NO. 98 - Key Map #534U
Address: 6518 Cherrydale Dr. PM#2-492962
City: Houston | Zip: 77087 | Lot Size: 69x110
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 1

HOUSE NO. 99
Address: 806 Monvil PM#2-537975
City: Navasota | Zip: 77868 | Lot Size: Irreg.
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 1CP

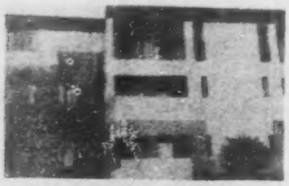
HOUSE NO. 100 - Key Map #334E
Address: 5421 Diane Court PM #2-549802
City: Spring | Zip: 77373 | Lot Size: 45x80
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 0



HOUSE NO. 101 - Key Map #611C
Address: 16536 Gold Ridge Ln. PM #2-542581
City: Houston | Zip: 77053 | Lot Size: 39x105
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 0



HOUSE NO. 102 - Key Map #412D
Address: 10031 Ridgecoral PM #2-571494
City: Houston | Zip: 77038 | Lot Size: 99x110
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 0



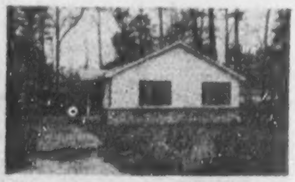
HOUSE NO. 103 - Key Map #451C
Address: 5675 Desoto Dr. #224 PM #2-481699
City: Houston | Zip: 77091 | Lot Size: Condo
Rms: 4 | Bdrms: 1 | Baths: 1 | Gar: 1CP

HOUSE NO. 104 - Key Map #571X
Address: 15511 Rose Ridge Ct. PM#2-493399
City: Missouri City | Zip: 77459 | Lot Size: 55x110
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 105 - Key Map #296M
Address: 713 Evergreen PM#4-96119
City: Porter | Zip: 77365 | Lot Size: 60x158
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 106 - Key Map #453H
Address: 9030 Laura Koppe PM #2-543456
City: Houston | Zip: 77078 | Lot Size: 61x120
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 1

HOUSE NO. 107 Key Map #451C
Address: 5635 Desoto Dr. #1018 PM #2-524067
City: Houston | Zip: 77091 | Lot Size: Condo
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 0

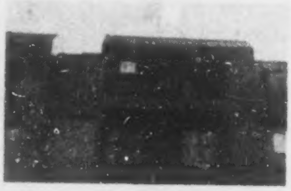


HOUSE NO. 108 - Key Map #455B
Address: 9429 Caddo PM#4-26479
City: Houston | Zip: 77078 | Lot Size: 54x130
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: 0

HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

HOUSE NO. 109 - Key Map #498B
Address: 746 Woodhue PM#2-524764
City: Channelview | Zip: 77530 | Lot Size: 60x120
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 1

HOUSE NO. 110 - Key Map #532U
Address: 8421 Hearth #22 PM #2-481041
City: Houston | Zip: 77054 | Lot Size: Condo
Rms: 6 | Bdrms: 2 | Baths: 2 | Gar: 0



HOUSE NO. 111 - Key Map #529V
Address: 1011 Forum W. Dr. #433 PM #2-517565
City: Houston | Zip: 77036 | Lot Size: Condo
Rms: 4 | Bdrms: 2 | Baths: 1½ | Gar: 1CP

HOUSE NO. 112 - Key Map #534S
Address: 5806 Southgood PM#4-26312
City: Houston | Zip: 77033 | Lot Size: 60x105
Rms: 6 | Bdrms: 2 | Baths: 1 | Gar: 1

HOUSE NO. 113 - Key Map #455N
Address: 7803 Queen St. PM #2-540920
City: Houston | Zip: 77028 | Lot Size: 50x120
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 114 - Key Map #459X
Address: 17701 Meadow Brk. Ln. PM #2-545048
City: Channelview | Zip: 77530 | Lot Size: 125x175
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1

HOUSE NO. 115 - Key Map #456M
Address: 12994 Gladden PM#2-523883
City: Houston | Zip: 77049 | Lot Size: 60x120
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 0

HOUSE NO. 116 - Key Map #532Q
Address: 2816 S. Bartell Dr. #311 PM #539956
City: Houston | Zip: 77054 | Lot Size: Condo
Rms: 3 | Bdrms: 1 | Baths: 1 | Gar: 1 CP

HOUSE NO. 117 - Key Map #413V
Address: 2147 William Tell PM #2-545810
City: Houston | Zip: 77093 | Lot Size: 60x150
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 118 - Key Map #411R
Address: 3110 Stallings Dr. PM#2-517976
City: Houston | Zip: 77088 | Lot Size: 60x100
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1

HOUSE NO. 119 - Key Map #453E
Address: 2926 Sherwick PM#4-23987
City: Houston | Zip: 77093 | Lot Size: 50x100
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 120 - Key Map #451S
Address: 2011 Spenwick #320 PM #2-554599
City: Houston | Zip: 77055 | Lot Size: Condo
Rms: 2 | Bdrms: 1 | Baths: 1 | Gar: 1CP

HOUSES TO BE AUCTIONED SATURDAY, FEBRUARY 8, 1986

HOUSE NO. 121 - Key Map #578A
Address 6547 Crestford PM#4-26103
City Pasadena | Zip 77505 | Lot Size 65x120
Rms 5 | Bdrms 3 | Baths 1½ | Gar 2, 1CP

HOUSE NO. 122 - Key Map #534S
Address 5009 Dieppe PM#4-16456
City Houston | Zip 77033 | Lot Size 60x110
Rms 4 | Bdrms 2 | Baths 1 | Gar 1

HOUSE NO. 123 - Key Map #372V
Address 912 Plaza Verde #18F PM #2-501701
City Houston | Zip 77038 | Lot Size Condo
Rms 4 | Bdrms 2 | Baths 1 | Gar 1CP

HOUSE NO. 124 - Key Map #534S
Address 5602 Pershing PM#4-14223
City Houston | Zip 77033 | Lot Size 60x110
Vacant Lot

HOUSE NO. 125
Address Rt. 4, Box 496-A PM#2-459748
City Conroe | Zip 77302 | Vacant Lot
Lot Size 70.9x753.2x59.4x714.5

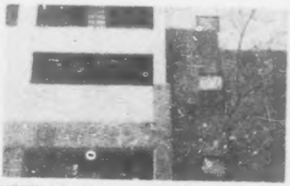
HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

HOUSE NO. 126 Key Map #495M
Address: 10237 Palestine PM#4-25523
City: Houston | Zip: 77029 | Lot Size: 52x105
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1CP

HOUSE NO. 127 Key Map #194X
Address: 14380 Woodland Rd PM#2-497684
City: Splendora | Zip: 77372 | Lot Size: NA
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: 0

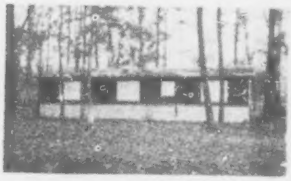
HOUSE NO. 128 - Key Map #454H
Address: 9112 Kelburn PM#2-387102
City: Houston | Zip: 77016 | Lot Size: 60x125
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 2

HOUSE NO. 129 Key Map #535J
Address: 7313 Gulf Freeway #1003 PM #4-28137
City: Houston | Zip: 77017 | Lot Size: Condo
Rms: 3 | Bdrms: 1 | Baths: 1 | Gar: 1CP



HOUSE NO. 130 - Key Map #451C
Address: 5665 DeSoto Dr. #325C PM #2-515435
City: Houston | Zip: 77091 | Lot Size: Condo
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1CP

HOUSE NO. 131 - Key Map #5345
Addres: 5126 Ridgeway PM#4-26177
City: Houston | Zip: 77033 | Lot Size: 50x100
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 1CP



HOUSE NO. 132 - Key May #379A
Address: 603 Elk Dr (Rt. 3) PM#4-25613
City: Crosby | Zip: 77532 | Lot Size: 200x145
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 0

HOUSE NO. 133 - Key Map #454H
Address: 8707 Lanewood PM#4-24024
City: Houston | Zip: 77016 | Lot Size: 42x145
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

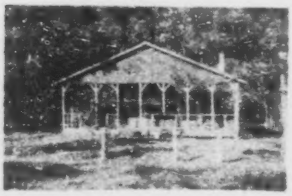
HOUSE NO. 134 - Key Map #454C
Address: 5225 Anthe PM#2-40619
City: Houston | Zip: 77016 | Lot Size: 53x190
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1CP

HOUSE NO. 135 - Key Map #573Q
Address: 12711 Scott St. PM#4-25207
City: Houston | Zip: 77047 | Lot Size: Condo
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: 2CP

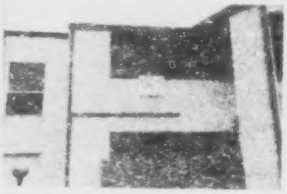
HOUSE NO. 136 - Key Map #529G
10555 Turtlewood Ct. #2516 PM #2-539698
City: Houston | Zip: 77072 | Lot Size: Condo
Rms: 3 | Bdrms: 1 | Baths: 1 | Gar: 1CP

HOUSE NO. 137 - Key Map #5345
Address: 4825 Burma PM#4-25334
City: Houston | Zip: 77033 | Lot Size: NA
Rms: 6 | Bdrms: 3 | Baths: 1 | Gar: 0

HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

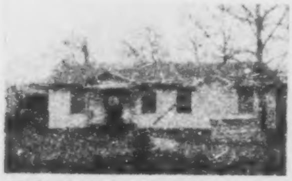


HOUSE NO. 138 PM#2-519514
Address: 1102 Yellowstone River Dr
City: Montgomery | Zip: 77356 | Lot Size: 100x125
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 0



HOUSE NO. 139 - Key Map #535J
Address: 7313 Gulf Freeway #709 PM #2536639
City: Houston | Zip: 77017 | Lot Size: Condo
Rms: 3 | Bdrms: 1 | Baths: 1 | Gar: 1CP

HOUSE NO. 140 - Key Map #532O
Address: 6523 Hearth Dr. #2 PM #2-481094
City: Houston | Zip: 77054 | Lot Size: Condo
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 1CP



HOUSE NO. 141 - Key Map #373Z
Address: 14505 Maeline PM#2 359148
City: Houston | Zip: 77039 | Lot Size: 60x116
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 0

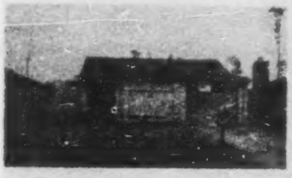
HOUSE NO. 142 - Key Map #455A
Address: 7638 Clairborne
City: Houston | Zip: 77016 | Lot Size: 60x120
Rms: 6 | Bdrms: 3 | Baths: 1 | Gar: 1CP

HOUSE NO. 143 - Key Map #658Q
Address: 1723 Canary Circle PM#2-537912
City: League City | Zip: 77573 | Lot Size: 66x114
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 1CP

HOUSE NO. 144 - Key Map #529G
10555 Turtlewood Ct. #2802 PM #2-550607
City: Houston | Zip: 77072 | Lot Size: Condo
Rms: 4 | Bdrms: 2 | Baths: 2 | Gar: 1CP

HOUSE NO. 145 - Key Map #661N
Address: 4911 Red Fish Reef PM#2-522456
City: Barcliff | Zip: 77518 | Lot Size: 50x100
Rms: 7 | Bdrms: 3 | Baths: 1 | Gar: 0

HOUSE NO. 146 - Key Map #535M
Address: 510 Gober PM#2-435744
City: Houston | Zip: 77017 | Lot Size: 60x110
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 1



HOUSE NO. 147 - Key Map #457J
Address: 13103 Nature Trail PM #2-542570
City: Houston | Zip: 77045 | Lot Size: 40x110
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1

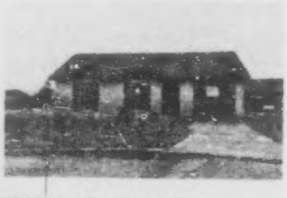
HOUSE NO. 148
Address: 1012 Leake St. PM#2-192676
City: Navasota | Zip: 77868 | Lot Size: 50x100
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 0

HOUSE NO. 149 - Key Map #571W
Address: 7006 Maczali Dr. PM#4 26053
City: Missouri City | Zip: 77459 | Lot Size: Duplex
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

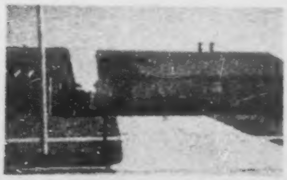
HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

HOUSE NO. 150 - Key Map #458A
Address: 16914 Folsom Dr | PM #542842
City: Houston | Zip: 77049 | Lot Size: Irreg
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 151 - Key Map #3338
Address: 3110 Cliff Swallow | PM #2-546298
City: Spring | Zip: 77373 | Lot Size: 44x110
Rms: 4 | Bdrms: 2 | Baths: 1½ | Gar: 1



HOUSE NO. 152 - Key Map #372N
Address: 1507 Birch Bend Circle | PM#2-536667
City: Houston | Zip: 77067 | Lot Size: Irrg
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 1

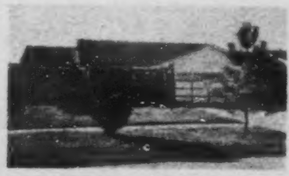


HOUSE NO. 153 - Key Map #611C
Address: 16531 Goldridge Ln. | PM #2-540652
City: Houston | Zip: 77053 | Lot Size: 34x110
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 154 - Key Map #406T
Address: 6622 New World Dr. | PM #2-570354
City: Katy | Zip: 77450 | Lot Size: 60x115
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 2

HOUSE NO. 155 - Key Map #572F
Address: 3219 Brookston | PM#2-524861
City: Houston | Zip: 77045 | Lot Size: 53x103
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: N

HOUSE NO. 156 - Key Map #494F
Address: 4629 Market | PM #2-544034
City: Houston | Zip: 77020 | Lot Size: NA
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 0



HOUSE NO. 157 - Key Map #571S
Address: 15114 Fourwinds | PM#2-518468
City: Missouri City | Zip: 77459 | Lot Size: 60x130
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 158 - Key Map #611B
Address: 16604 Gold Ridge Ln. | PM #2-540869
City: Houston | Zip: 77053 | Lot Size: 34x110
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 159 - Key Map #446R
Address: 19435 Lazy Valley Dr. | PM#2-519972
City: Katy | Zip: 77449 | Lot Size: 48x105
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 0

HOUSE NO. 160 - Key Map #529N PM#2-537137
Address: 12300 Brookglade Circle #96
City: Houston | Zip: 77099 | Lot Size: 30x20
Rms: 5 | Bdrms: 2 | Baths: 2½ | Gar: 2

HOUSE NO. 161 - Key Map #412P
Address: 1519 W. Gulf Bank | PM#4-26508
City: Houston | Zip: 77088 | Lot Size: Average
Rms: 6 | Bdrms: 3 | Baths: 1½ | Gar: 2CP

HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

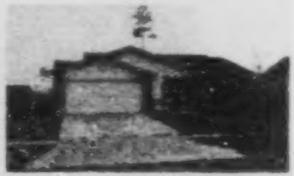
HOUSE NO. 162 - Key Map #571W
Address: 6639 Indian Falls PM#2-449864
City: Missouri City | Zip: 77459 | Lot Size: 65x110
Rms: 7 | Bdrms: 4 | Baths: 2 | Gar: 0

HOUSE NO. 163 - Key Map #456B
Address: 8618 Valley Ledge PM#4-27358
City: Houston | Zip: 77078 | Lot Size: 60x105
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 164 - Key Map #412B
Address: 10026 Laseber Ct. PM #2-554125
City: Houston | Zip: 77038 | Lot Size: Irreg
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 1

HOUSE NO. 165 - Key Map #575H
Address: 9107 Barton Ave. PM #548478
City: Houston | Zip: 77034 | Lot Size: 50x100
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 1

HOUSE NO. 166 - Key Map #291L
Address: 3535 Spanish Acorn Ln. PM#2-476784
City: Spring | Zip: 77389 | Lot Size: 70x115
Rms: 6 | Bdrms: 2 | Baths: 1 | Gar: 2



HOUSE NO. 167 - Key Map #456R
Address: 14211 Dartwood PM #2-544684
City: Houston | Zip: 77049 | Lot Size: 60x120
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 168 - Key Map #297J
Address: 3206 Abbey Field Ln. PM#2-501900
City: Porter | Zip: 77365 | Lot Size: 60x115
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 169 - Key Map #407P
Address: 17726 Autumn Trial PM#2-479840
City: Houston | Zip: 77088 | Lot Size: 65x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 170 - Key Map #185Y
Address: 34 Forest Lane PM #2-545740
City: Conroe | Zip: 77308 | Lot Size: 136.80x299.40
Rms: 8 | Bdrms: 4 | Baths: 2 | Gar: 0

HOUSE NO. 171 - Key Map #529G
10855 Turtlewood Ct. #1805 PM #2-525769
City: Houston | Zip: 77072 | Lot Size: Condo
Rms: 4 | Bdrms: 2 | Baths: 2 | Gar: 1CP

HOUSE NO. 172 - Key Map #638P
Address: 602 Pixie Dr. PM#2-519595
City: League City | Zip: 77573 | Lot Size: 130x65
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 173 - Key Map #371R
Address: 11799 Old Telegraph Rd PM#2-486888
City: Houston | Zip: 77067 | Lot Size: 60x115
Rms: 7 | Bdrms: 4 | Baths: 2 | Gar: 2

HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

HOUSE NO. 174 · Key Map #570Z
Address: 15834 Rosebriar Dr | PM #2-548226
City: Missouri City | Zip: 77459 | Lot Size: 60x110
Rms: 6 | Bdrms: 4 | Baths: 2 | Gar: 2

HOUSE NO. 175 · Key Map #611B
Address: 16234 Corsair | PM #2-550723
City: Houston | Zip: 77053 | Lot Size: 60x105
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 1

HOUSE NO. 176 · Key Map #368Y PM#4-27270
Address: 13431 Wimbledon Oaks Dr
City: Houston | Zip: 78130 | Lot Size: 90x120
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

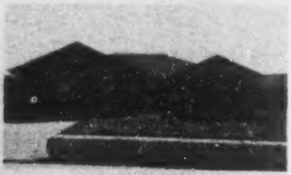
HOUSE NO. 177 · Key Map #368T
Address: 13843 Rosette | PM#2-470906
City: Cypress | Zip: 77429 | Lot Size: 60x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 178 · Key Map #535X
Address: 7938 Glen Vista | PM#2-523563
City: Houston | Zip: 77061 | Lot Size: 65x115
Rms: 8 | Bdrms: 4 | Baths: 2 | Gar: 1CP

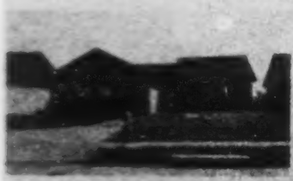
HOUSE NO. 179 · Key Map #660J
Address: 2900 Dunrich Court | PM #2-545792
City: League City | Zip: 77573 | Lot Size: 85x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 180 · Key Map #410J
Address: 8330 Autumn Wind Dr | PM#2-517147
City: Houston | Zip: 77040 | Lot Size: 46x103
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 2CP

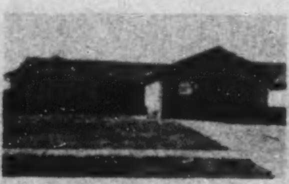
HOUSE NO. 181 · Key Map #610G
Address: 8307 Bee Meadow | PM#4-25424
City: Missouri City | Zip: 77459 | Lot Size: 60x110
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2



HOUSE NO. 182 · Key Map #610C
Address: 8215 Quail Hills Dr | PM#2-495733
City: Missouri City | Zip: 77459 | Lot Size: 60x110
Rms: 6 | Bdrms: 4 | Baths: 2 | Gar: 2



HOUSE NO. 183 · Key Map #467G
Address: 17019 Cairnsoan | PM#2-494103
City: Houston | Zip: 77089 | Lot Size: 59x106
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2



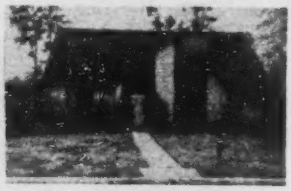
HOUSE NO. 184 · Key Map #570W
Address: 2018 Summer Place Dr. | PM#2-584256
City: Missouri City | Zip: 77489 | Lot Size: 60x115
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 185 · Key Map #369V
Address: 9902 Crescent Moon | PM#2-474175
City: Houston | Zip: 77064 | Lot Size: 75x115
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

HOUSE NO. 186 - Key Map #571X
Address 15714 Ironside Cr. Dr. PM#2-495929
City Missouri City | Zip 77459 | Lot Size 60x100
Rms 6 | Bdrms 3 | Baths 2 | Gar 2

HOUSE NO. 187 - Key Map #527L
Address 16010 Cerca Blanca PM#2-576244
City Houston | Zip 77083 | Lot Size 63x125
Rms 8 | Bdrms 3 | Baths 2 | Gar 2

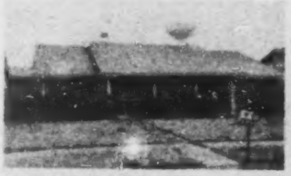


HOUSE NO. 188 - Key Map #297T
Address 3715 Golden Lake PM#2-479064
City Kingwood | Zip 77339 | Lot Size 75x120
Rms 8 | Bdrms 4 | Baths 2 | Gar 2

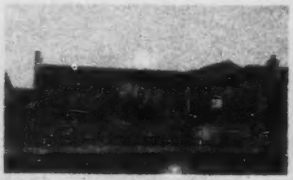
HOUSE NO. 189 - Key Map #616G
Address 11602 S. Oak Ct. PM#2-516525
City Houston | Zip 77089 | Lot Size 125x150x125
Rms 8 | Bdrms 3 | Baths 2½ | Gar 2

HOUSE NO. 190 - Key Map #332U
Address 16210 North Trail Dr. PM#2-520621
City Houston | Zip 77072 | Lot Size 68x110
Rms 6 | Bdrms 3 | Baths 2 | Gar 2

HOUSE NO. 191 - Key Map #529W
Address 11311 Mullholland PM #2-540410
City Stafford | Zip 77477 | Lot Size 60x105
Rms 6 | Bdrms 2 | Baths 2 | Gar 2

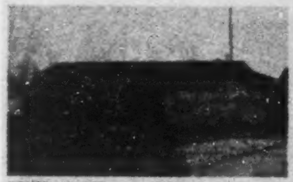


HOUSE NO. 192 - Key Map #369Y
Address 11039 Hidden Bend Dr. PM #2-547369
City Houston | Zip 77064 | Lot Size 65x120
Rms 7 | Bdrms 3 | Baths 2 | Gar 2



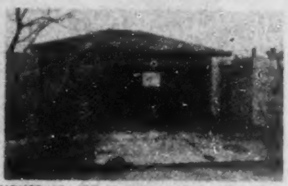
HOUSE NO. 193 - Key Map #446T
Address 2226 Gray Hawk Dr. PM#2-521001
City Katy | Zip 77449 | Lot Size 67x104
Rms 6 | Bdrms 3 | Baths 2 | Gar 2

HOUSE NO. 194 - Key Map #449R
Address 10554 Hammerly PM#2-455932
City Houston | Zip 77043 | Lot Size 26.25x76.5
Rms 6 | Bdrms 3 | Baths 2½ | Gar 2CP



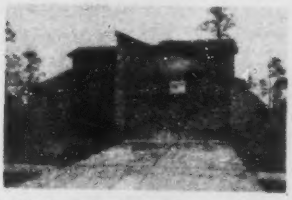
HOUSE NO. 195
Address 518 William Morton Dr. PM#4-25893
City Richmond | Zip 77469 | Lot Size 65x110
Rms 7 | Bdrms 4 | Baths 2 | Gar 2

HOUSE NO. 196 - Key Map #610G
Address 17335 Edgehaven Dr. PM #2-540227
City Missouri City | Zip 77489 | Lot Size 60x160
Rms 5 | Bdrms 3 | Baths 2 | Gar 2

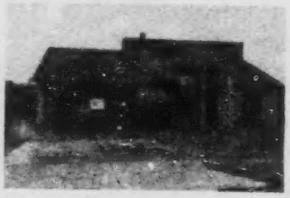


HOUSE NO. 197 - Key Map #410J
Address 8334 Windy Oaks Dr. PM #2-570037
City Houston | Zip 77040 | Lot Size 53x87
Rms 5 | Bdrms 2 | Baths 2 | Gar 2CP

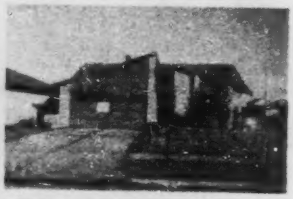
HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986



HOUSE NO. 198 - Key Map #376T
Add: 10734 Kentington Oak Dr. PM #2-541358
City: Humble | Zip: 77338 | Lot Size: 60x105
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2



HOUSE NO. 199 - Key Map #371U
Address: 3315 Creek Grove PM #4-25978
City: Houston | Zip: 77078 | Lot Size: 60x105
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2



HOUSE NO. 200 - Key Map #408Q
Address: 2502 Kite Hill Dr. PM#2-501033
City: Houston | Zip: 77041 | Lot Size: NA
Rms: 5 | Bdrms: 3 | Baths: 2 | Gar: 2

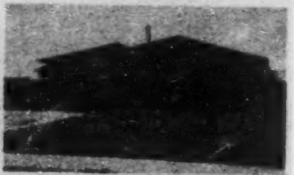
HOUSE NO. 201 - Key Map #458P
Address: 2502 Harpers Ferry PM#2-537674
City: League City | Zip: 77573 | Lot Size: 87x125
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 202 - Key Map #579A
Address: 10006 Carlow PM#2-522524
City: LaPorte | Zip: 77471 | Lot Size: 63x139
Rms: 6 | Bdrms: 4 | Baths: 2 | Gar: 2

HOUSE NO. 203 - Key Map #457S
Address: 14614 Loudres PM#2-516307
City: Houston | Zip: 77049 | Lot Size: 61x120
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 204
Address: 2829 21st Ave. North PM#2-438629
City: Texas City | Zip: 77590 | Lot Size: 65x100
Rms: 7 | Bdrms: 3 | Baths: 2 | Gar: 2

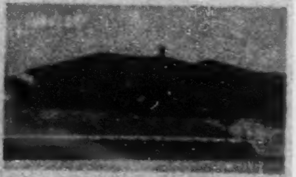
HOUSE NO. 205 - Key Map #372J
Address: 11746 Apple Bough Cr. PM #2-548224
City: Houston | Zip: 77067 | Lot Size: NA
Rms: 6 | Bdrms: 4 | Baths: 2 | Gar: 2



HOUSE NO. 206 - Key Map #571W
Address: 6647 West Fuqua Dr. PM#4-86585
City: Missouri City | Zip: 77459 | Lot Size: 65x90
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2

HOUSE NO. 207 - Key Map #416L
Address: 12319 Kingslake Forest Pm #2-547818
City: Houston | Zip: 77044 | Lot Size: 55x104
Rms: 6 | Bdrms: 4 | Baths: 2 | Gar: 2

HOUSE NO. 208 - Key Map #456V
Address: 14146 Flair PM #2-572856
City: Houston | Zip: 77049 | Lot Size: 63x180
Rms: 6 | Bdrms: 3 | Baths: 2 | Gar: 2



HOUSE NO. 209 - Key Map #457Z
Address: 1454 Willersley Ln. PM#2-594986
City: Channelview | Zip: 77530 | Lot Size: 60x180
Rms: 7 | Bdrms: 4 | Baths: 2 | Gar: 2

HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

HOUSE NO. 210 - Key Map #571V
Address: 4697 Oakside PM#4-27397
City: Houston Zip: 77053 Lot Size: 65x110
Rms: 8 Bdrms: 3 Baths: 2 Gar: 2CP

HOUSE NO. 211 - Key Map #658Q
Address: 1828 Eagle PM#2-471242
City: League City Zip: 77573 Lot Size: 45x115
Rms: 5 Bdrms: 3 Baths: 2 Gar: 2

HOUSE NO. 212 - Key Map #408R
Address: 7619 Log Cradle Dr. PM#2-524855
City: Houston Zip: 77041 Lot Size: 46x105
Rms: 6 Bdrms: 3 Baths: 2 Gar: 2

HOUSE NO. 213 - Key Map #410L
Address: 7835 Terra Cotta PM #541371
City: Houston Zip: 77040 Lot Size: 40x67
Rms: 5 Bdrms: 1 Baths: 1 Gar: 1

HOUSE NO. 214 - Key Map #369U
Address: 9206 Goodmeadow Dr. PM #2-549065
City: Houston Zip: 77064 Lot Size: 50x110
Rms: 5 Bdrms: 3 Baths: 1½ Gar: 1

HOUSE NO. 215 - Key Map #446W
Address: 1803 Bugle Run PM #2-545945
City: Katy Zip: 77449 Lot Size: 50x130
Rms: 5 Bdrms: 2 Baths: 2 Gar: 1

HOUSE NO. 216 - Key Map #611B
Address: 5417 Ridge Wind Ln. PM#2-53715
City: Houston Zip: 77053 Lot Size: N
Rms: 4 Bdrms: 2 Baths: 1 Gar: 0

HOUSE NO. 217 - Key Map #328H
Address: 11807 Westwold Dr. PM#4-26781
City: Tomball Zip: 77375 Lot Size: 60x110
Rms: 6 Bdrms: 3 Baths: 2 Gar: 2

HOUSE NO. 218 - Key Map #611C
Address: 4923 Porter Ridge ?
City: Houston Zip: 77053 Lot Size: 60x110
Rms: 5 Bdrms: 3 Baths: 2 Gar: 1

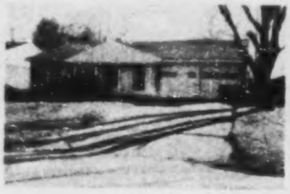
HOUSE NO. 219 - Key Map #293X
Address: 3230 Lucinda Lane PM #2-550656
City: Spring Zip: 77373 Lot Size: 60x120
Rms: 5 Bdrms: 2 Baths: 1½ Gar: 1

HOUSE NO. 220 - Key Map #611C
Address: 5138 Ravenridge PM#2-455367
City: Houston Zip: 77053 Lot Size: 60x110
Rms: 6 Bdrms: 3 Baths: 2 Gar: 2

HOUSE NO. 221 - Key Map #536V
Address: 714 Armor PM#2-525568
City: Pasadena Zip: 77502 Lot Size: 60x110
Rms: 5 Bdrms: 3 Baths: 1 Gar: 1

HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

HOUSE NO. 222 - Key Map #412M
Address 9019 Berwyn PM#2-525309
City Housto | Zip 77037 | Lot Size 62x110
Rms 5 | Bdrms 3 | Baths 1½ | Gar 1



HOUSE NO. 223 - Key Map #572N
Address 4111 Grapevine PM #2-540462
City Houston | Zip 77045 | Lot Size 60x110
Rms 6 | Bdrms 3 | Baths 2 | Gar 2

HOUSE NO. 224
Address Rt 2, Box 2780 PM #2-543817
City Conroe | Zip 77327 | Lot Size Irreg
Rms 5 | Bdrms 3 | Baths 1 | Gar 0

HOUSE NO. 225 - Key Map #534Y
Address 6147 Beldart PM #2-548320
City Houston | Zip 77033 | Lot Size 50x110
Rms 8 | Bdrms 4 | Baths 1 | Gar 1CP

HOUSE NO. 226 - Key Map #195W
Address 1450 Dogwood Ln PM#2-475315
City Splendora | Zip 77372 | Lot Size 200x200
Rms 6 | Bdrms 2 | Baths 1½ | Gar 0

HOUSE NO. 227 - Key Map #534Y
Address 6518 Flamingo PM#2-449390
City Houston | Zip 77087 | Lot Size 65x115
Rms 8 | Bdrms 3 | Baths 1 | Gar 0

HOUSE NO. 228 Key Map #529Q
Address 10014 Wilcrest PM #2-503053
City Houston | Zip 77077 | Lot Size Condo
Rms 4 | Bdrms 2 | Baths 1½ | Gar 1CP

HOUSE NO. 229 - Key Map #659J
Address 329 E. Wilkins PM#4-262
City League City | Zip 77575 | Lot Size 100x15
Rms 8 | Bdrms 3 | Baths 1 | Gar 0

HOUSE NO. 230 - Key Map #498G
ddress 604 Pemberton PM#2-475914
ity Channelview | Zip 77530 | Lot Size 250x131
Rms 5 | Bdrms 2 | Baths 1 | Gar 0

HOUSE NO. 231 - Key Map #534N
Address 5338 Bataan PM#4-25289
City Houston | Zip 77033 | Lot Size 52.5x110
Rms 6 | Bdrms 3 | Baths 2 | Gar 2

HOUSE NO. 232 - Key Map #529V
10202 Forum Park Dr. #249 PM #2-502140
City Houston | Zip 77036 | Lot Size Condo
Rms 4 | Bdrms 2 | Baths 2 | Gar 1CP

HOUSE NO. 233
Address 210 Easy St PM#2-496087
City Magnolia | Zip 77353 | Lot Size 90x120
Rms 4 | Bdrms 2 | Baths 1 | Gar 0

HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

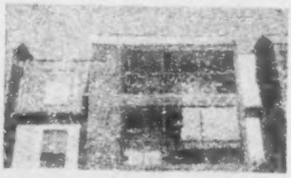
HOUSE NO. 234 · Key Map #455F
Address: 8016 Lynette PM#2-399987
City: Houston | Zip: 77028 | Lot Size: 55x120
Rms: 6 | Bdrms: 3 | Baths: 1 | Gar: 1

HOUSE NO. 235 · Key Map #451C
Address: 5675 Desoto Dr. #220 PM #2-498439
City: Houston | Zip: 77091 | Lot Size: Condo
Rms: 5 | Bdrms: 2 | Baths: 2 | Gar: 1CP

HOUSE NO. 236 · Key Map #575K
Address: 8026 Winthrop PM#2-521398
City: Houston | Zip: 77075 | Lot Size: 61x134
Rms: 6 | Bdrms: 3 | Baths: 1 | Gar: 1CP

HOUSE NO. 237 · Key Map #535J
7313 Gulf Freeway #1005 PM #2-543381
City: Houston | Zip: 77017 | Lot Size: Condo
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1CP

HOUSE NO. 238 · Key Map #455D
Address: 8922 Caddo PM# 21833
City: Houston | Zip: 77028 | Lot Size: 60x120
Rms: 6 | Bdrms: 3 | Baths: 1 | Gar: 1CP



HOUSE NO. 239 · Key Map #529V
10403 Fotuni Park Dr. #335 PM #2-492958
City: Houston | Zip: 77036 | Lot Size: Condo
Rms: 3 | Bdrms: 1 | Baths: 1 | Gar: 1CP

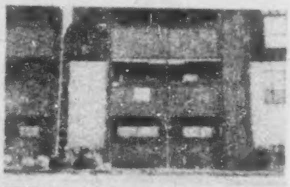
HOUSE NO. 240
Address: 709 Beaumont PM#2-539573
City: Anahauc | Zip: 77514 | Lot Size: 60x135
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 1CP

HOUSE NO. 241 · Key Map #455T
Address: 7995 Cinderella PM#4-26789
City: Houston | Zip: 77016 | Lot Size: 40x105
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 242 · Key Map #534J
Address: 5831 Grace Ln. PM#2-524141
City: Houston | Zip: 77021 | Lot Size: 50x100
Rms: 5 | Bdrms: 2 | Baths: 1 | Gar: 0

HOUSE NO. 243 · Key Map #414Q
Address: 4410 Gaston PM #2553450
City: Houston | Zip: 77093 | Lot Size: 75x115
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 0

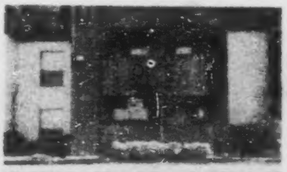
HOUSE NO. 244 · Key Map #453F
Address: 144 Grothe PM#2-480863
City: Houston | Zip: 77027 | Lot Size: 50x198
Rms: 4 | Bdrms: 1 | Baths: 1 | Gar: 2



HOUSE NO. 245 · Key Map #372V
Address: 212 Plaza Verde Dr #24F PM #2-497910
City: Houston | Zip: 77038 | Lot Size: Condo
Rms: 4 | Bdrms: 2 | Baths: 1½ | Gar: 1CP

HOUSES TO BE AUCTIONED SUNDAY, FEBRUARY 9, 1986

HOUSE NO. 246 - Key Map #413R
Address: 1921 Werwick | PM#2-411917
City: Houston | Zip: 77093 | Lot Size: 63x112
Rms: 6 | Bdrms: 3 | Baths: 1 | Gar: 0



HOUSE NO. 247 - Key Map #372Y
Address: 212 Palza Verde #F16 | PM #2-514437
City: Houston | Zip: 77038 | Lot Size: Condo
Rms: 4 | Bdrms: 2 | Baths: 1 | Gar: 1CP

HOUSE NO. 248 - Key Map #164L
Address: 36 Liberty Creek | PM#4-25858
City: Cleveland | Zip: 77327 | Lot Size: 1.765 acre
Rms: 5 | Bdrms: 3 | Baths: 1 | Gar: 0

HOUSE NO. 249 - Key Map #454N
Address: 2514 Creston | PM#2-410238
City: Houston | Zip: 77026 | Lot Size: 60x125
Rms: 8 | Bdrms: 3 | Baths: 1 | Gar: 0

HOUSE NO. 250
Address: 5135 Dogwood Ln | PM#4-26443
City: Conroe | Zip: 77301 | Lot Size: 165x140
Vacant Lot

QUESTION 7A. If the VA had paid back the guaranty for each of the homes auctioned on February 5, 1986, how much would the total VA cost have been? Compare that cost to appraised value of homes at the time to the auction.

QUESTION 7B. Compare the cost of paying off the guarantees to the costs accrued by the VA by buying back those properties, upkeep, rehabilitation, vandalism, taxes, interest and any other costs associated with the VA ownership of these properties. Compare those costs to the net profit of the auction.

RESPONSE 7A. Payment of the maximum claim under guaranty on all guaranteed loan properties would have totaled $4,972,980. The appraised value at foreclosure was $11,035,035. The appraised value at auction was $6,116,875.

RESPONSE 7B. Had VA paid maximum claims on all of the guaranteed loan foreclosures, the total cost would have been $4,972,980.

The total cost to VA of acquiring and managing the guaranteed loan properties is estimated to be $10,309,710. The net proceeds from the auction sale of these properties was $4,639,293. These properties had been in VA's inventory an average of 21.8 months. Therefore, the net loss to VA from the acquisition and resale of these particular properties is $5,670,417. For these particular properties, based on what is now known about the prices actually obtained at resale, it would have been $697,437 less expensive to have paid the maximum claims and to not have acquired the properties.

At the time of the foreclosure sales, however, the properties had an appraised market value of $11,035,035. Had these properties been able to be sold at that figure, less the customary 5% selling expense, the net sales figure would have been $10,483,284 and it would have been $5,510,304 more expensive to have paid the guaranty rather than acquiring and reselling the properties.

LOAN GUARANTY: PROPOSED LEGISLATION

QUESTION 8. If S. 2052, a bill to raise the estimated FY 1986 loans activity to $17.6 billion, is enacted before March 1, what adjustments will be made to the announced curbs on the loan guaranty program?

RESPONSE 8. The President's sequestration order places a limitation on the dollar level of new loan guarantees the VA could grant in 1986. This limitation is legally binding and once the limit was reached the Agency would have to suspend operations. However, Congress has recently passed legislation increasing the new guarantee loan base from $12.1 billion to $18.2 billion. It is felt that at this base level, prior to sequestration, that the Agency can take steps to insure the operation of the program through the fiscal year. The Agency is continuing to look into what steps can and need to be taken to insure the operation of this program.

PENSION

Question:

1.A) In the VA Budget in Brief for FY 1986, it states that the compensation and pension obligations were net of collections of overpayment. The budget books for FY 1987 make no such reference.

Response:

1A) The footnote that stated obligations were net of collections of overpayments in the 1986 as well as the 1985 Budget provided a transition from the original 1984 Budget. For the 1984 Budget the Agency presented net obligations to reflect collections of overpayments as a budgetary asset (repayment program) which funded a like amount of obligations. This type of presentation was dropped for the 1985 budget presentation. The footnote was provided to explain changes from the original 1984 budget estimate. Once 1984 no longer appeared in the budget it was felt that the footnote could be removed.

Question:

1.B) Please indicate the amounts of overpayments particularly for the pension account for FY 1985, 1986 and 1987.

Response:

1.B) The amount of Pensions overpayments as well as the collections of those overpayments are as follows:

(dollars in millions)

	1985	1986	1987
Overpayments	$216.4	$219.2	$221.3
Collections	$168.2	$172.2	$181.4

EDUCATION

Question 1. During the development of the proposed FY 1987 budget, what were the VA and DOD views on the termination of Chapter 30, the New GI Bill and on the reinstatement of Chapter 32, VEAP?

Response 1. The decision to close enrollments in the New GI Bill, effective October 1, 1986, was made during DOD's budget process, based upon an assessment of the impact the increased education benefits had on the recruitment and retention of qualified personnel in the military. We understand that DOD has provided the committee with data which supports this assessment.

Question 2.

How did you project the percentages needed to achieve Gramm/Rudman mandated savings in VA education accounts?

RESPONSE:

The process used to arrive at the amounts and the resulting percentage reductions is explained as follows:

For each sequesterable appropriation, a 4.3 percent reduction was applied to the total sequesterable budgetary resources. For example, in the Readjustment Benefits appropriation a 4.3 percent sequester was applied to the estimate of new budget authority of $917 million. This budget authority level includes the funds provided in the appropriation ($826 million) as well as the program supplemental request ($91 million).

The 4.3 percent reduction was then applied to each program, project and activity (PPA) as defined in the Conference report of the Continuing Resolution. In the Readjustment Benefits account, the PPA reflected each activity listed in the budget justification submitted to Congress. Attached (Attachment 1) is the PPA report on Readjustment Benefits submitted to Congress as part of the February 1, 1986 report.

For sequestered entitlements, such as the Readjustment Benefits account, benefit payments will have to be reduced to meet the required reduction. This is necessary because section 252(e) of the act prohibits the denial of eligibility for benefits because of the sequester order. Payments for sequestered programs will be reduced between March 1 and September 30 by the percent necessary to reduce the estimate of obligations by the sequestered amount. The payment reductions were determined as follows:

Education and training: The education and training payment reductions were determined by dividing the sequestered level (from the PPA) by the estimated obligations between March 1986 and September 1986. Based upon this methodology, it is anticipated that the 8.7 percent reduction will achieve the sequestered reduction of $33,885,000.

Vocational rehabilitation: In determining the reduction for vocational rehabilitation, it is necessary to examine the composition of this program. The vocational rehabilitation program is made up of monthly subsistence payments as well as providing for books, tuition, and equipment necessary to begin training. It was determined that it would be difficult to sequester the payment for tuition, fees and books as these payments reflect actual costs (already paid to schools), and that the reduction would be taken from the monthly subsistence payments.

It should be noted that the total reduction to the vocational rehabilitation program would be 7.73 percent. This is determined in the same manner as the other activities. However, by excluding the tuition payments, the reduction to the subsistence rates would be 13.1 percent.

Grants: The reduction to the grant program was taken in the same manner as the education benefits. The sequester amount, as identified in PPA, was compared to the obligation estimate during the sequester period. It is estimated that a reduction of 7.85 percent in specially adapted housing and 7.91 percent in adaptive equipment will achieve the sequestered reductions.

A chart (Attachment 2) is provided detailing the methodology used in determining the percentage reductions.

Attachment 1

Page 1 of 1

PROGRAM, PROJECT, ACTIVITY DETAIL
($000)

Agency: Veterans Administration

Account Title: Readjustment Benefits

Account ID code: 29-00-0137-X-1-702-A; 36-0137

Source: Public Law 99-160 (1986 Appropriation)

Program, project, activity	Budgetary Resources Base	Budgetary Resources Sequester
1. Vietnam era veterans	$ 669,861	$ 28,805
2. Sons and daughters	108,087	4,648
3. Spouses and widow (ers)	10,055	432
4. Vocational rehabilitation	102,774	4,419
5. Housing grants	14,029	603
6. Automobiles, adaptive equipment, maintenance and repair	12,194	524
Total	$ 917,000 1/	$ 39,431

1/ Estimate includes 1986 program supplemental of $91,000,000.

Attachment 2

Readjustment Benefits
1986 Gramm-Rudman
(dollars in thousands)

Program, Project, Activity	1987 Middle Column (incl. suppl.)	Estimate Obligations February	Balance	Sequester	% Reduction
Vietnam era veterans	$686,693	$351,446			
Sons and daughters	110,803	61,873			
Spouses and widow(ers)	10,308	5,447			
Subtotal	807,804	418,766	389,038	33,885	8.71
Vocational rehabilitation	105,356	48,130	57,226	4,419	7.73
(Subsistence)			(33,698)	(4,419)	(13.12)
(in-kind)			(23,528)	-0-	-0-
Housing grants	14,382	6,693	7,689	603	7.85
Automobiles, Adapt. Equipment	12,500	5,871	6,629	524	7.91
Total	$940,042	$479,460	460,582	39,431	8.57

Question: 3.A) Provide, by account for DVB, DM&S and DMA, a breakdown for FY 1984, 1985 and 1986 of the appropriation made, the amount spent and what was done with the surpluses in every case where the entire appropriation was not spent.

Answer: The attached table is a breakdown by appropriation for FY 1984, 1985 and 1986 of the appropriation made, the amount obligated and the amount lapsed. The following is an explanation of the lapsed amounts:

FY 1984
(dollars in thousands)

Medical Care:	$3,451	
	1,610	- Readjustment Counseling
	1,512	- Community Nursing Homes
Medical & Prosthetic Research	$ 35	- Miscellaneous
MAMOE	$1,177	
	1,045	- Contractual Services
	132	- All Other
GOE	$2,133	
	1,300	- Personal Services under due to lower employment
	833	- Minor differences from plan throughout the appropriation

FY 1985

Medical Care:	$5,245	
	599	- Readjustment Counseling
	621	- Excess reimbursements
	3,052	- Community Nursing Homes
	973	- State Home Programs
Medical & Prosthetic Research	$ 355	- Primarily unused contractual service funding
MAMOE:	$2,093	
	1,151	- Lapsed per Treasury Postal Service Act
	942	- All other primarily contractual services

GOE:	$5,019	
DVB	$2,671	
- Payroll	1,800	with lower FTEE for 1986 the department could not hire up at the end of the year.
- Telecommunications	800	the large increases expected with deregulation did not occur.
ODM&T:	$ 424	
- Supplies	122	Obligation of paper purchased through GPO was slower than expected.
- Telecommunications	100	the large increase expected with deregulation did not occur.
- Contracts	150	contracts not obligated at full amounts
- Travel	50	
Administrator:	$ 400	
- CESVE	350	an advertising contract and a direct mailing did not occur as planned.

Breakdown by Appropriation, Amount Obligated and Amount Lapsed

Federal Funds:	Appropriations FY 1984 Actuals	FY 1985 Actuals	FY 1986 Estimates	Obligations FY 1984 Actuals	FY 1985 Actuals	FY 1986 Estimates	Amount Lapsed FY 1984 Actuals	FY 1985 Actuals
Benefit Programs:								
Compensation 1/	9,952,512	10,232,458	10,465,000	9,937,577	10,254,880	10,470,635		
Pensions	3,916,000	3,809,870	3,834,000	3,878,998	3,846,873	3,834,000		
Burial Benefits	128,388	132,572	127,999	128,388	132,572	127,999		
Subtotal C&P	13,996,900	14,174,900	14,426,999	13,944,963	14,234,325	14,432,634		
Readjustment Benefits 1/	1,443,200	1,130,800	877,569	1,401,028	1,168,168	941,724		
PEPS	51,000			47,127	55,091	45,300		
Veterans Job Training	130,000			64,120	58,818	17,562		
Veterans Insurance & Indemnities	7,400	11,000	9,745	7,701	11,512	10,765		
Loan Guaranty	260,000	306,600	200,000	2,323,386	2,458,906	2,573,400		
Subtotal	15,888,500	15,623,300	15,514,313	17,788,325	17,986,820	18,021,385	0	0
Medical Programs:								
Medical Care 2/	8,244,414	8,941,169	9,130,137	8,300,863	8,936,274	9,245,088	3,451	5,245
Medical & Prosthetic Research	217,680	192,695	181,127	190,299	226,634	186,230	35	355
MAMOE	66,552	67,891	51,222	65,576	65,798	51,222	1,177	2,093
Grants for State Homes	18,000	34,500	20,822	21,618	29,136	39,654		
Grants to Philippines	500	500	474	585	505	926		
Subtotal	8,547,146	9,236,755	9,383,782	8,578,941	9,258,347	9,523,120	4,663	7,693
Construction Programs:								
Construction, Major	345,692	568,194	485,544	416,256	309,991	646,606		
Construction, Minor	185,378	199,823	131,061	133,758	124,404	150,223		
Subtotal	531,070	768,017	616,605	550,014	434,395	796,829	0	0
GOE & Miscellaneous Accounts								
General Operating Expenses	715,676	753,954	712,835	730,028	765,296	731,655	2,133	5,019
Grants to State Cemeteries	3,000	5;000	2,839	892	1,031	2,200		
Total, GOE & Misc	718,676	758,954	715,674	730,920	766,327	733,855	2,133	5,019
TOTAL, APPROPRIATIONS	25,685,392	26,387,026	26,230,374	27,648,200	28,445,889	29,075,189	6,796	12,712

NOTE: Benefit, Construction, and Grant Programs carry forward unobligated balances to the next fiscal year.

1/ FY 1986 includes program supplementals ($363,000,00 for Compensation and $91,000,000 for Readjustment Benefits)
2/ Medical Care carried forward $55,272,000 from FY 1985 to FY 1986.

Question:

3. B) Why do you need a FY 1986 supplemental for specially adapted housing?

Response 3.B.: The 1986 appropriation of $826 million would support a level (prior to sequestration) of $12.5 million for specially adapted housing. Based upon 1985 and actual experience in the first quarter of 1986, an additional $1.9 million will be required in 1986. This is the amount included in the $91 million Readjustment supplemental for specially adapted housing.

Question:

3. C) Why do you need a FY 1986 supplemental for education? Provide the rationale for the projected education program activity used to project a need for a supplemental. Provide figures for comparison including all quarters of FY 1984, 1985 and the 1st quarter of FY 1986.

Response 3.C.: The 1986 appropriation provided $826 million for the Readjustment Benefits appropriation. This funding level was $200 million below the level requested in the 1986 President's Budget. Based upon actual experience for the last part of 1985 and the first quarter of 1986, it appears that an appropriated funding level of $917 million will be required in 1986. The workload projections for the Readjustment Benefits activity are based upon a cohort analysis by year of separation.

The following chart compares educational activity on a quarterly basis for 1984, 1985 and 1986:

Caseload - Fiscal Year to Date Basis

		1984	1985	1986
1st Quarter	- Veterans	378,309	284,673	218,637
	- Dependents	55,289	46,621	41,677
2nd Quarter	- Veterans	445,993	337,147	
	- Dependents	61,923	52,791	
3rd Quarter	- Veterans	487,070	368,490	
	Dependents	65,256	56,275	
4th Quarter	- Veterans	528,468	402,281	
	Dependents	71,194	61,958	

Question: 4. Please provide a detailed justification for the Administration's proposal to repeal the new GI Bill effective October 1, 1986 and a full cost-benefit analysis for this proposal for FY 1987 through FY 1995 specifically including statistics and assumptions which justify the statement on page 1-31 of Volume I of the VA Budget books concerning the DOD determination that the new GI Bill is not necessary for recruitment and may be a disincentive for retention. Please state savings and costs separately for the Veterans Administration and the Department of Defense.

Response 4: Attached (Attachment 1) is a copy of the Major Policy Initiatives paper supporting the closing of the New GI Bill on October 1, 1986. Also attached (Attachment 2) is the breakout of the budget numbers supporting the table in the initiative paper. Note as indicated in attachment 2 the savings increase dramatically towards 1991. Through 1991, it is estimated that the government-wide savings resulting from closing the New GI Bill on October 1, 1986 will be $246 million (outlays would be reduced by $230 million). Preliminary estimates indicate that savings from 1992 - 1995 will total approximately $1 billion (almost $600 million in the VA and $400 million from the DOD-Civilian trust fund).

We defer to the Department of Defense in determining the cost-effectiveness of this program as a recruitment and retention tool. We understand that DOD has already provided data supporting its conclusions regarding the cost-effectiveness of this program to both the House and Senate Veterans Committees. One such report is the Economic Research Laboratory report, "Analysis of the Effects of the New GI Bill".

THE NEW GI BILL

Department of Defense
Veterans Administration

Since July 1, 1985, the Department of Defense (DOD) and the Veterans Administration (VA) have been jointly funding and administering a 3-year trial program of enhanced educational benefits (the new GI bill) to aid in recruiting military personnel. The President's budget proposes to end this test program on October 1, 1986 (rather than July 1, 1988 as in current law), and resume the veterans educational assistance program (VEAP), which has been suspended during the new GI bill test period.

FUNDING SUMMARY

(In millions of dollars)

	1985	*1986*	*1987*	*1988*	*1989*	*1990*	*1991*
Current services:							
Budget authority	127	309	262	227	164	304	407
Outlays	−34	−154	−9	72	139	338	467
President's budget:							
Budget authority	n.a.	n.a.	107	216	199	266	330
Outlays	n.a.	n.a.	−18	100	130	242	323
Deficit reduction:							
Outlays	n.a.	n.a.	9	−28	9	96	144

Note.—Negative outlays result in the early years when the contributions of the members of the armed services are accruing and educational outlays have not yet begun.

PROGRAM HISTORY AND CURRENT STATUS

From 1977 to 1985, military personnel received educational benefits under the veterans educational assistance program (VEAP), which is entirely funded by DOD but is administered by VA.

- The basic benefit under VEAP is contributory, with DOD matching members' contributions on a 2:1 basis up to a maximum of $2,700 (the Government's share is $5,400).
- VEAP included an additional non-contributory benefit of up to $12,000 that could be targeted as a recruiting incentive for critical occupations. Only the Army made extensive use of this benefit, called the Army college fund.
- VEAP also included a non-contributory benefit of $4,000 that was targeted to critical occupations in the Reserves.
- Under VEAP, the active forces were meeting 100% of their recruiting objectives; over 90% were high school graduates in the top three test groups.

Over the administration's strenuous objections, the 1985 DOD authorization bill created a new educational benefits program, the all-volunteer force educational assistance test program (the new GI bill). This test program runs from July 1, 1985 to July 1, 1988; VEAP is suspended during this period. The new GI bill:

- requires individuals to contribute $1,200, which is matched 8:1 by a Government contribution of $9,600. This benefit is available to all personnel enlisting during the test period;
- provides for additional non-contributory benefits of up to $14,400, which can be targeted to critical occupations. Currently only the Army offers this additional benefit, known as the new Army college fund. The program also contains a provision for an additional reenlistment benefit, which no service now plans to offer;
- contains a non-contributory benefit of $5,040 for all reservists who enlist or reenlist during the test period; and
- requires VA to fund the basic benefit for active forces.

Preliminary estimates indicate that the new GI bill has had a negligible effect on the quality of recruits. It also appears that participation rates under the new program will far exceed those experienced under VEAP, thus contributing to the program's higher cost.

ADMINISTRATION PROPOSAL

Under the administration's proposal the following actions would be taken:

- The new GI bill test would be ended on October 1, 1986.
- The VEAP program would be resumed on that same date.

The resumption of VEAP, in place of the new GI bill, will provide both significant long-term cost savings and a potential improvement in manning our Armed Forces.

- The Government cost of the basic benefit under VEAP is much lower than under the new GI bill, but, even so, provides a recruiting incentive sufficient to meet manning requirements.
- The overly generous basic benefit of the new GI bill—fostering higher participation rates (and costs) than intended—will likely result in highly skilled recruits leaving the service in order to use their benefits.
- By reducing the level of the basic benefit while retaining a comparable level of additional benefits for the Army, the return to VEAP will actually increase the relative value of the Army recruiting incentive. The Army, historically, has had the most difficult recruiting problem.

In sum, enactment of this proposal will enable the administration to maintain the high level of success in recruiting and retention that it has have experienced in recent years, while realizing significant long-term cost savings to the Government.

14-Feb-86

NET UNIFIED BUDGET: EFFECT OF ENDING THE NEW GI BILL
TEST ON OCT. 1, 1986 AND RESUMING VEAP AT THAT TIME

**** OUTLAYS ****

CURRENT SERVICES	1985	1986	1987	1988	1989	1990	1991
VEAP PROGRAM	182	231	218	204	184	195	206
VEAP RECPTS	-212	-271	-111	-70	-159	-170	-181
NEW GI BILL RECPTS	-4	-151	-186	-181	-58	0	0
NEW GI BILL (DOD)	0	37	70	100	118	147	161
NEW GI BILL (VA)	0	0	0	19	54	166	281
TOTAL	-34	-154	-9	72	139	338	467

PROPOSED LEGISLATION	1985	1986	1987	1988	1989	1990	1991
VEAP PROGRAM	182	231	218	214	211	221	228
VEAP RECPTS	-212	-271	-170	-180	-192	-192	-188
GIBILL RECPTS	-4	-151	-101	0	0	0	0
GIBILL (DOD)	0	37	35	47	66	79	77
GIBILL (VA)	0	0	0	19	45	134	206
TOTAL	-34	-154	-18	100	130	242	323

DELTA FROM CURR SERV	1985	1986	1987	1988	1989	1990	1991
VEAP PROGRAM	0	0	0	10	27	26	22
VEAP RECPTS	0	0	-59	-110	-33	-22	-7
GIBILL RECPTS	0	0	85	181	58	0	0
GIBILL (DOD)	0	0	-35	-53	-52	-68	-84
GIBILL (VA)	0	0	0	0	-9	-32	-75
TOTAL	0	0	-9	28	-9	-96	-144

VEAP TRACK

**** OUTLAYS ****

CURRENT SERVICES	1985	1986	1987	1988	1989	1990	1991
VEAP PROGRAM	182	231	218	204	184	195	206
VEAP RECPTS	-212	-271	-111	-70	-159	-170	-181
NET VEAP	-30	-40	107	134	25	25	25

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PROPOSED LEGISLATION

VEAP PROGRAM           182    231    218    214    211    221    228
VEAP RECPTS           -212   -271   -170   -180   -192   -192   -188
---------------------------------------------------------------------
NET VEAP               -30    -40     48     34     19     29     40

DELTA FROM CS

VEAP PROGRAM             0      0      0     10     27     26     22
VEAP RECPTS              0      0    -59   -110    -33    -22     -7
---------------------------------------------------------------------
NET VEAP                 0      0    -59   -100     -6      4     15


NEW GI BILL TRACK

**** OUTLAYS ****

                      1985   1986   1987   1988   1989   1990   1991
CURRENT SERVICES

GIBILL RECPTS           -4   -151   -186   -181    -58      0      0
GIBILL (DOD)             0     37     70    100    118    147    161
GIBILL (VA)              0      0      0     19     54    166    281
---------------------------------------------------------------------
NET GI BILL             -4   -114   -116    -62    114    313    442

PROPOSED LEGISLATION

GIBILL RECPTS           -4   -151   -101      0      0      0      0
GIBILL (DOD)             0     37     35     47     66     79     77
GIBILL (VA)              0      0      0     19     45    134    206
---------------------------------------------------------------------
NET GI BILL             -4   -114    -66     66    111    213    283

DELTA FROM CS

GIBILL RECPTS            0      0     85    181     58      0      0
GIBILL (DOD)             0      0    -35    -53    -52    -68    -84
GIBILL (VA)              0      0      0      0     -9    -32    -75
---------------------------------------------------------------------
NET GI BILL              0      0     50    128     -3   -100   -159
```

14-Feb-86

NET UNIFIED BUDGET: EFFECT OF ENDING THE NEW GI BILL
TEST ON OCT. 1, 1986 AND RESUMING VEAP AT THAT TIME

**** BUDGET AUTHORITY ****

CURRENT SERVICES	1985	1986	1987	1988	1989	1990	1991
VEAP PROGRAM	290	442	294	245	291	273	276
VEAP RECPTS	-212	-271	-111	-70	-159	-170	-181
NEW GI BILL RECPTS	-4	-151	-186	-181	-58	0	0
NEW GI BILL (DOD)	53	289	265	213	34	23	15
NEW GI BILL (VA)	0	0	0	20	56	178	297
TOTAL	127	309	262	227	164	304	407

PROPOSED LEGISLATION	1985	1986	1987	1988	1989	1990	1991
VEAP PROGRAM	290	442	353	355	329	303	291
VEAP RECPTS	-212	-271	-170	-180	-192	-192	-188
NEW GI BILL RECPTS	-4	-151	-101	0	0	0	0
NEW GI BILL (DOD)	53	289	25	21	15	9	5
NEW GI BILL (VA)	0	0	0	20	47	146	222
TOTAL	127	309	107	216	199	266	330

DELTA FROM CS	1985	1986	1987	1988	1989	1990	1991
VEAP PROGRAM	0	0	59	110	38	30	15
VEAP RECPTS	0	0	-59	-110	-33	-22	-7
NEW GI BILL RECPTS	0	0	85	181	58	0	0
NEW GI BILL (DOD)	0	0	-240	-192	-19	-14	-10
NEW GI BILL (VA)	0	0	0	0	-9	-32	-75
TOTAL	0	0	-155	-11	35	-38	-77

*** BUDGET AUTHORITY ****

CURRENT SERVICES	1985	1986	1987	1988	1989	1990	1991
VEAP PROGRAM	290	442	294	245	291	273	276
VEAP RECPTS	-212	-271	-111	-70	-159	-170	-181
NET VEAP	78	171	183	175	132	103	95

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PROPOSED LEGISLATION

VEAP PROGRAM                     290     442     353     355     329     303     291
VEAP RECPTS                     -212    -271    -170    -180    -192    -192    -188
 ------------------------------------------------------------------------------------
NET VEAP                          78     171     183     175     137     111     103

DELTA FROM CS

VEAP PROGRAM                       0       0      59     110      38      30      15
VEAP RECPTS                        0       0     -59    -110     -33     -22      -7
 ------------------------------------------------------------------------------------
NET VEAP                           0       0       0       0       5       8       8



 *** BUDGET AUTHORITY ****

                                1985    1986    1987    1988    1989    1990    1991
CURRENT SERVICES

GIBILL RECPTS                     -4    -151    -186    -181     -58       0       0
GIBILL (DOD)                      53     289     265     213      34      23      15
GIBILL (VA)                        0       0       0      20      56     178     297
 ------------------------------------------------------------------------------------
NET GI BILL                       49     138      79      52      32     201     312

PROPOSED LEGISLATION

GIBILL RECPTS                     -4    -151    -101       0       0       0       0
GIBILL (DOD)                      53     289      25      21      15       9       5
GIBILL (VA)                        0       0       0      20      47     146     222
 ------------------------------------------------------------------------------------
NET GI BILL                       49     138     -76      41      62     155     227

DELTA FROM CS

GIBILL RECPTS                      0       0      85     181      56       0       0
GIBILL (DOD)                       0       0    -240    -192     -19     -14     -10
GIBILL (VA)                        0       0       0       0      -9     -32     -75
 ------------------------------------------------------------------------------------
NET GI BILL                        0       0    -155     -11      30     -46     -85
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EXPLANATION OF TABLES

BUDGET AUTHORITY

VEAP PROGRAM:	DOD Matching and Kicker payments + Member contributions
VEAP RECPTS:	Member contributions offset VA Budget Authority
NEW GI BILL RECPTS:	Member contributions offset VA Budget Authority
NEW GI BILL (DOD):	DOD accrual payments (Kickers and Reserve benefit) + Trust
NEW GI BILL (VA):	VA obligations for Basic benefit payments

OUTLAYS

VEAP PROGRAM:	VA payments for training and refunds
VEAP RECPTS:	Member contributions offset VA outlays
NEW GI BILL RECPTS:	Member contributions offset VA outlays
NEW GI BILL (DOD):	Payments (for Kickers/Reserve) from Educational Benefits
NEW GI BILL (VA):	VA payments for the Basic benefit

Question

5. Will the Veterans' Administration be obligated to pay any administration costs during FY 1987 for the new GI Bill particularly with respect to the administration of any supplemental benefits provided by the Department of Defense?

Answer

The processing of chapter 106 and chapter 30 original education claims will require approximately 15 FTE in FY 1987.

Question:

6. Why are the DOD portions of the FY 1987 obligations for the All Volunteer Force Educational Assistance program being carried as an obligation in the VA budget books?

Response 6: These obligations are included as gross obligations of the program. Obligations for the DOD and DOT portions of the All Volunteer Force Educational Assistance programs are reimbursable and are offset directly by payments from DOD and DOT. Therefore, there is no net effect on either budget authority or outlays in the VA's budget for these portions of the programs.

VOCATIONAL REHABILITATION

Question:

1. A) Since the VA's first priority is to provide for the service-connected veterans, why did you choose to cut vocational rehabilitation subsistence benefits by 13% and GI Bill benefits by 8.7%? I believe that you have the discretion under the law to have realigned those savings so as not to have forced service-connected veterans to receive the smaller benefit. This is particularly ironic since I understand non-service-connected pension veterans who participate in vocational rehabilitation will not suffer a reduction in benefits since their benefits are paid for out of the compensation and pension account (protected under Gramm/Rudman) instead of readjustment benefits which funds education and vocational rehabilitation programs.

Response 1.A. On an average, payments made to or on behalf of these veterans are being reduced 7.73%. Because payments made for tuition, fees, books, supplies and equipment are made on behalf of the veteran to institutions and suppliers, it was decided to apply the 7.73% reduction of $4.4 million to just the subsistence allowance rather than tuition, fees, etc., so the veteran would not have to pay 7.73% for these expenses out of pocket. Although subsistence rates will be reduced 13.1%, the overall effect for the average veteran will be a reduction of 7.73%. It should be noted that unlike the service-connected veteran the non-service connected veteran does not receive an additional subsistence allowance for participation in vocational training. The program for new pensioners pays the cost of tuition, fees and equipment for eligible veterans. This payment from the pension account is exempt from sequestration under P.L. 99-177.

Question:

1. B) Is the readjustment benefits account considered one line item, or are the line items from which savings must be found separated within the readjustment benefits account into education and vocational rehabilitation? Is everything under the Compensation and Pension account exempt, (i.e. staff, travel, printing, pension vocational rehabilitation program, etc.) or only payment to compensation and pension beneficiaries?

Response 1.B.: In the Readjustment Benefits account savings must be found from six line items (or program, project and activities as defined in PL 99-177). These are: a) Vietnam era veterans; sons and daughters; spouses and widow(ers); vocational rehabilitation; specially adapted housing; and automobiles, adaptive equipment maintenance and repair. All payments in the Compensation and Pensions accounts, including the pension vocational training program are exempt from sequestration. Burial benefits, currently funded in the Compensation and Pensions appropriation are not exempt from sequestration. Personnel costs, travel, printing, etc. are funded in the General Operating Expenses appropriation and are not exempt from sequestration.

Question:

1. C) **What** would happen if enrollments go up or down **significantly?** If your estimate of enrollments are correct, will you have enough money in the readjustment benefits account for the entire year? Your budget documents indicate plans to request a $91 million supplemental for FY 1986 -- have you been given reason to believe that supplementals will be granted for FY 1986 (by whom)? If you receive a FY 1986 supplemental how would the 4.3% sequester be applied? Since you plan to transfer $8 million from DM&S to DVB, how will that affect a need for a FY 1986 **supplemental?**

Response 1.C.

We have not been told by anyone in Congress that the supplemental would be granted. However, the amount sequestered has been based on the estimate of total budgetary resources which includes the supplemental. The sequester has been agreed upon by OMB, CBO, and GAO. It is our understanding that the full sequestration based on the enacted appropriation and the supplemental will take place in March. This means that when the supplemental is enacted, the full amount of $91 million will be available since the 4.3% would have already been removed.

Statement

2. In 1980, the law was amenoed by Public Law 96-466 to require the VA to expand and focus the services to veterans receiving vocational rehabilitation. The added requirements are 1) to provide employment assistance and job placement services and 2) extended evaluations and vocational rehabilitation training beyond the expiration of entitlement for veterans determined to have a serious employment handicap. I have several questions relative to these statutory changes.

A) I believe that the heart of DVB direct services program is the vocational rehabilitation and counseling service. The program was designed to help service-connected disabled veterans overcome their disabilities, receive education and training with the goal of finding suitable employment. With the expanded responsibilities mandated by Public Law 96-466 and Public Law 98-543 (pension/vocational rehabilitation bill) explain the severe staffing decreases in vocational rehabilitation.

1981 - 650
1985 - 625 (actual FTEE level 600)
1986 - 573
1987 - 593 (request)

Question

2. A) * Is your caseload decreasing at the same percentage as your staffing levels?

Answer

Employment in the VR&C Service from FY 81 through FY 86 is given below:

FY 81 Actual	FY 82 Actual	FY 83 Actual	FY 84 Actual	FY 85 Actual	FY 86 Current Estimate	FY 87 Budget Estimate
665	653	636	620	597	572	*593
%Change	-2	-4.4	-6.7	-10.3	-14	

*President's Budget

Vocational rehabilitation caseload (program participants) from FY 81 through FY 86 is given below:

FY 81 Actual	FY 82 Actual	FY 83 Actual	FY 84 Actual	FY 85 Actual	FY 86 Current Estimate	FY 87 Budget Estimate
29,818	30,919	31,266	29,024	26,901	*27,600	**27,100
%Change	+3.7	+4.9	-2.7	-9.8	+2.5	

Question

2. A) • What is the average caseload for each vocational rehabilitation specialist (VRS)? How is the VRS's time divided between doing initial interviews, extended evaluations, determinations of special employment handicaps, employment services or other services?

Answer

The current approach in providing rehabilitation services and assistance under Chapter 31 can be characterized as personal, comprehensive assistance to the population being served. Each service-disabled veteran who applies for rehabilitation benefits and is eligible for and entitled to vocational rehabilitation services, is provided an individual evaluation by a professional VA counseling psychologist. A veteran's eligibility and entitlement to rehabilitation services is determined by a counseling psychologist and, in concert with the veteran and a vocational rehabilitation specialist, it is decided how the veteran can best be provided rehabilitation assistance. Then the counseling psychologist, vocational rehabilitation specialist, and veteran develop a rehabilitation plan. This plan sets forth the overall rehabilitation goals, objectives, actions to be taken, evaluation criteria, and overall responsibilities. The plan is then carried out with the vocational rehabilitation specialists providing individualized assistance to the veteran through the program, including employment placement and followup services.

Counseling psychologists average about 25 case completions per month. This rate has been found to be too high and promotes inadequate development of cases. First time appointments for chapter 31 applicants now average 79 days from the date the application is received in the VA to the appointment date. Current VRS workload averages about 190 chapter 31 veterans per VRS. At this level, we are not able to adequately supervise all chapter 31 participants or provide minimally acceptable employment assistance services.

Question

2. A) * What percentage of the VRS's time is taken up implementing the new vocational rehabilitation law for pensioners?

Answer

The new programs recently enacted by PL 98-543 were implemented on February 1, 1985 with existing VR&C personnel resources. This was necessary due to overall budgetary restraints in all DVB program elements. While implementation of these programs and increased efforts at the placement of disabled veterans have placed a strain on resources, we believe that the implementation has been initiated without serious effect on other program areas.

Program statistics for the first 9 months (February 2, 1985, through October 31, 1985) have been tabulated. In the category of veterans less than age 50, 242 persons have received personal evaluations. It was determined that a vocational goal was realistic for 73 of these veterans with 39 electing a program.

While the 242 veterans evaluated thus far is significantly lower than our projection, the number of veterans evaluated and found feasible for the program has been increasing steadily. As these numbers increase, we anticipate that staff time will also increase.

Question

2. B) * Define a serious employment handicap.

Answer

The term "serious employment handicap" means a significant impairment of a veteran's ability to prepare for, obtain or retain employment consistent with such veteran's abilities, aptitudes, and interests. A veteran who has been found to have an employment handicap shall also be held to have a serious employment handicap if he or she has:

(1) A neuropsychiatric service-connected disability rated at 30 percent or more disabling, or

(2) Any other service-connected disability rated at 50 percent or more disabling.

A veteran with a nonneuropsychiatric service-connected disability may be found to have a serious employment handicap even though the disability is rated at 30 or 40 percent disabling, when either of the following conditions exist:

(1) The veteran has a prior history of poor adjustment in training and employment, and special efforts will be needed if the veteran is to be rehabilitated; or

(2) The veteran's situation presents special problems due to nonservice-connected disability, family pressures, etc., and a number of special and supportive services are needed to effect rehabilitation.

Question

2. B) * Has the addition of the term serious employment handicap helped or hindered determinations of a need for vocational rehabilitation?

Answer

The term serious employment handicap has identified veterans who fall within this criteria for special consideration in provision of services such as extension of basic termination date for services, training in excess of 48 months when necessary to ensure employment. It has been a useful criteria in that it provides program managers a means of monitoring and providing appropriate services to the seriously disabled.

Question

2. B) * Is every veteran with a serious employment handicap given extended entitlement if he/she doesn't find a "suitable" job? Please provide several examples to illustrate when a veteran with serious employment handicap would be given a extension and when one would not.

Answer

Each veteran for whom an employment handicap has been established must also have a determination concerning serious employment handicap using the criteria given above in the definition. This determination does not in itself result in extended entitlement either in terms of extending the basic termination date of 12 years or in providing services for a period in excess of 48 months. The criteria for extension of either of these entitlements is based upon each individual veterans circumstances. While it is true that serious employment determination is a condition for these extensions of entitlement the individual circumstances determine the granting of such benefits.

An example of extended termination date is illustrated by the case of a veteran who is disabled by reason of paraplegia who was trained subsequent to the Korean Conflict in the field of animal husbandry and pet grooming and who pursued this field successfully until he developed an allergy to animal dander. Since the basic termination date has passed the serious employment determination allowed an extension to allow reentry into training and subsequent employment in a new field of endeavor.

An example of extension of training beyond 48 months is illustrated by the instance of a veteran with a service connected disability of nephritis who was trained as an aircraft mechanic and licenses in airframe and power plants. His medical condition exacerbated and he subsequently had one kidney removed. He was unable to maintain employment as an aircraft mechanic and was found eligible for additional training and was entered into a degree program in air port management which would utilize his previous experiences. This would result in a total training time of approximately 60 months which is an extension of 12 months beyond the basic 48 month entitlement. It should be noted that this extension beyond 48 months requires the review and approval of the Vocational Rehabiltation and Counseling Officer to ensure proper application of the regulations and procedures.

Question

2. C) What percentage of veterans with a disability rated below 40% are determined to have a serious employment handicap in order to receive vocational rehabilitation?

Answer

This information is not readily available and cannot be obtained in a timely fashion. An ad hoc report has been requested and will be available in approximately 10 days.

Question

4. Please comment on whether it would be advisable to restrict vocational rehabilitation services in time (entitlement) and in substance (to vocational training and job placement) for veterans rated less than 30-percent disabled.

Answer

It is not advisable to restrict vocational rehabilitation services in time or in substance for veterans rated less than 30-percent disabled since to do so would undermine a fundamental fact in the field of rehabilitation; that is, each person is unique and has individual needs. Existing authorizing legislation recognizes this fact mandating the formulation of an individualized written rehabilitation plan for each chapter 31 program participant. Program regulations also acknowledge that any two veterans with disability ratings of less than 30% may vary markedly in the degree of their employment handicap based on factors such as the nature of the service-connected disability, the existence of non-service connected disabilities, any deficiencies in education and training or the prevalence of negative attitudes toward the disabled. To limit services on the basis of the disability rating percentage would hamper the Agency's ability to assure veterans receive services as individuals rather than as a member of a class or group.

Question

5. Are the staff in the vocational rehabilitation service trained to provide employment services? If not, what plans do you have to correct this deficiency?

Answer

VR&C staff are trained in providing quality rehabilitation services. They are not adequately trained to providing quality employment services, especially placement services. Employment placement is a time and labor intensive process, and becomes more labor intensive when staff are not trained to efficiently provide placement services.

We have provided training in employment services at VR&C Annual Training Conferences. Nevertheless, VR&C staff continue to require comprehensive, professional training and skill development in provision of employment services to assure rehabilitation resources provided chapter 31 veterans are properly used.

INSURANCE

Serviceman's Group Life Insurance Fund (SGLI)

Question

1. A) What is the net increase in the amount of insurance in force in the Servicemen's Group Life Insurance (SGLI) and Veterans Group Life Insurance (VGLI) programs as a result of the increase in the maximum coverage provided in Public Law 99-166?

Answer

The in force coverage increased by $51,049,477,000.

Question

1. B) Please provide a breakdown of the number of beneficiaries in both the SGLI and VGLI programs according to the amount of coverage selected.

Answer

Effective January 1, 1986, under the provisions of PL 99-166, all active duty and ready reserve members were automatically insured for $50,000, notwithstanding any previous requests for reduction. Reports on the number of requests for reduction since January 1, 1986, are not yet available. However, we assume that such requests will be proportionate to requests for reduction which existed prior to January 1, 1986. Therefore, the figures as of December 31, 1985, are shown for illustration.

SGLI and VGLI Amounts of Coverage

Amount of Insurance Coverage	Number of Individuals Covered
$5,000	2,678
$10,000	2,990
$15,000	3,244
$20,000	99,243
$25,000	3,656
$30,000	3,751
$35,000	3,553,845
	3,669,407

Question

1. C) Please provide an analysis of projected premium increases as a result of the increased maximum coverage authorized by Public Law 99-166 and as originally scheduled prior to the legislative change.

Answer

The premium rate for SGLI is currently set at a level below a break-even point in order to reduce the SGLI Contingency Reserve. The premium rate is scheduled to be increased periodically until the break-even point is reached. Because the increase in face value will result in a faster reduction of the contingency reserve, the premium rates will be increased more rapidly under the higher coverage. The following shows total estimated collections under the $35,000 maximum face amount and the new $50,000 face amount

FACE	FY 85	FY 86	FY 87
$50,000	NA	$145,850,000	$178,200,000
$35,000	$107,025,000	$108,320,000	$118,170,000
Increase	---	+$37,530,000	+$60,030,000

Question

1. D) Will the legislatively authorized increase in the maximum coverage for the VGLI program require additional transfers from the SGLI fund to maintain the solvency of the VGLI program? If so, what is the projected amount to be transferred for FY 1986 and FY 1987?

Answer

A slight increase in the transfers from Prudential's SGLI reserves to the VGLI reserves will be necessary as the face amount of VGLI gradually increases. In FY 1986 the additional transfer is estimated at $600,000 and in FY 1987 at $1,000,000. Only veterans who were separated after January 1, 1986, are eligible for $50,000.

Question

2. Why have estimated premiums paid to carriers and obligations increased more than premiums withheld between FY 1986 and FY 1987?

Answer

The line item under obligations titled, "premiums paid to carrier" includes both premiums collected from the uniformed services and transfers of contingency reserves between the VA and Prudential. The following breakdown shows the FY 1986 and FY 1987 calculations of that line item.

	FY 1986	FY 1987
Premiums withheld from Service Pay	$145,850,000	$178,200,000
General Operating Expenses	- 510,000	- 520,000
Net Premium Transfer	$145,340,000	$177,680,000
Conting. Reserves Transfer	+38,650,000	+46,100,000
Premiums Paid to Carrier	$183,990,000	$223,780,000

Question

3. A) At what amount will the contingency reserve fund be maintained during FY 1987 and what is the current level of the reserve fund?

Answer

The total contingency reserve as of June 30, 1985, held by both the VA and Prudential was $299.7 million. By June 30, 1987, the total contingency reserve will be an estimated $211.6 million.

Question

3. B) and C) Why is the redemption of the fund's securities necessary to maintain the level of the carrier's reserves? Has there been a dramatic decrease in the recent size of the contingency reserve which requires the premium increase and sale of securities?

Answer

Premiums paid by insured servicemembers are used by the carrier to pay claims and expenses and to maintain necessary reserves, including a "contingency reserve," which is held to ensure that sufficient funds are available to cover fluctuations in mortality rates and unforeseen contingencies.

The Group Policy that the Veterans Administration purchased from the carrier provides that when the Administrator determines that the funds held in the contingency reserve are sufficient to guard against unforeseen contingencies and mortality fluctuations, any surplus funds will be transferred to the SGLI revolving fund, and invested in U.S. Treasury certificates. This provision was invoked in 1982 and to date, $129 million, including interest, is held in the revolving fund. In addition, approximately $173 million is held by the carrier as contingency reserves and is invested as part of their overall portfolio.

The VA and carrier Actuarial staffs have determined that $70 million in contingency reserves is a sufficient level. Since SGLI is a group insurance program and therefore does not issue dividends, the equitable way to reduce the combined contingency reserve and revolving fund to the appropriate level is through a premium reduction to below the "break-even" point. In this manner, current insureds, who have contributed to the build-up in the reserve, will benefit through reduced premiums.

Since the premiums are below the "break-even" point, current income (premiums and interest) is not sufficient to pay current claims and expenses. The difference is drawn from the contingency reserve and will ultimately reduce it to the appropriate level of $70 million. At that point, in order to maintain it at that level, funds will need to be withdrawn from the revolving fund (redemption of securities). Meanwhile, premiums will have been gradually increased so that at a certain point in time the contingency reserve will be $70 million, the revolving fund will be $0 and current income will be sufficient to meet claims and expenses.

Despite the setting of a premium at below the break-even point and the claims arising from the Arrow Air crash in Gander, Newfoundland, there has not been a dramatic decrease in the reserve. However, we do expect a gradual decline over the next few years which will result in an increase in premiums and the sale of securities, as described above.

INSURANCE

National Service Life Insurance (NSLI) Fund

Question

What is the "all other" obligation amount comprised of?

Answer

The "all other" obligation amount shown under "Fund Highlights" on page 3-21 of the FY 1987 President's Budget is comprised of matured endowments, cash surrenders, disability claims, interest on dividend credits and deposits and liens granted.

BURIAL BENEFITS

Question 1: I understand there is money which remained unused in the DVB account which was appropriated in 1985 for payment of burial benefits. How much money remained, in what account, and what will be done with the surplus? Have there been surpluses in the past? (If so, list) Can this money be reprogrammed to offset Gramm/Rudman reductions required in the readjustment account?

Response 1: In 1985, $14.2 billion was appropriated to the Compensation and Pensions accounts (including a $175 million supplemental). It was originally estimated that $142.2 million would be required for burial benefits and miscellaneous assistance. Only $132.6 million was required because of lower workload and payment levels than originally projected. The $9.6 million difference between the original request and the actual obligation incurred was shown as a transfer to Compensation to help offset enacted 1985 rate increases. A surplus of $5.6 million was shown in Compensation at the end of 1985. This surplus will be used to partially offset the 1986 3.1% cost of living increase.

Recently funds remaining unobligated in the Compensation and Pensions appropriations for 1983, 1984 and 1985 amounted to $13.1 million, $65.1 million and $5.6 million respectively. As a percent of the total amount appropriated it has been .09% (1983), .5% (1984) and .03 (1985).

Administrative provisions of the HUD-Independent Agencies Appropriation Act preclude a transfer of unobligated funds into another appropriation account. Only new budget authority may be transferred. However, it should be noted that reprogramming authority will be requested to fully fund items in the burial benefits activity which are administered on a contractual basis. These funds, which total approximately $1.3 million, will come from the pensions activity. This represents more of an activity transfer than an appropriation transfer.

QUESTION:

2. Since DVB pays burial benefits, what is the rationale for having a separate Department of Memorial Affairs?

Response:

The Department of Memorial Affairs is responsible for 143 cemeterial installations including 111 national cemeteries, located throughout the United States and has a threefold mission: to provide, upon request, for the interment in any national cemetery with available grave space the remains of eligible deceased service persons and discharged veterans (together with their spouses and certain dependents) and to permanently maintain these graves; the provision of headstones and markers for graves in national and State veterans cemeteries, and on request for veterans graves located in private cemeteries; and for administering a State Cemetery Grants program which complements the national cemetery program. The functions of this Department represent one of the three major missions of the VA, and have been structured into the organization so as to facilitate the efficient management of these sensitive responsibilities and unique field facilities. The Chief Memorial Affairs Director serves concurrently as Director of the National Cemetery System, a statutory position established by Public Law 93-43 (38 U.S.C. 1000).

The burial benefits administered by the Department of Veterans Benefits are financial in nature, and involve the processing of cash payments to individual beneficiaries. By contrast, the Department of Memorial Affairs is responsible for operating the largest complex of cemeteries in the United States. The functions of its managers and employees include provision of burial space to meet present and future needs; determining eligibility for interment and availability of space in the location requested; holding interment services; opening and closing graves; maintaining cemetery property; marking graves, and setting, realigning and cleaning headstones.

Issues of ethical, historical, environmental, and operational importance are involved which require technical expertise, employee sensitivity, and supervisory controls quite separate from the management of cash payments. The Department of Memorial Affairs has been steadily increasing productivity levels at the national cemetery level, and makes appropriate use of administrative services at other VA facilities (i.e. personnel, fiscal and supply offices at VA medical centers) so as to avoid unnecessary duplication of effort. The organization is structured within the VA as a separate Department in order to provide for an effective span of control and in order to achieve its statutory mission as efficiently as possible.

Question 3: Please describe the legislation which will be proposed to restrict eligibility for the VA plot allowance, including the rationale and justification for this legislative proposal and an analysis of how the projected savings of $31.2 million were determined.

Response 3: Legislation has been transmitted to Congress proposing the change in the eligibility requirements for the burial plot allowance. The impact of this legislation would be to make the eligibility requirements for the plot allowance the same as the eligibility for the basic burial allowance. This would limit eligibility to veterans with a service-connected disability, veterans in receipt of a pension, and certain other limited categories of war-time veterans.

Under current law, all wartime veterans whose deaths are non-service connected are entitled to a $150 plot allowance. This allowance is not paid to veterans buried in a national cemetery. This proposal is consistent with actions already taken by Congress in connection with the basic $300 burial allowance (the companion program to the plot allowance).

If this proposal is enacted, it is estimated that it will reduce the number of $150 plot allowance by 208,000, thus saving $31.2 million in 1987.

DISCRETIONARY ACCOUNTS

Question:

1) List the amount of discretionary funds available in DM&S and DVB, by account, what these funds are used for, how they are affected by the FY 1986 sequester and FY 1987 budget proposal. Be sure to include printing, travel and training.

Response: The amounts of discretionary funds available in DVB are shown below:

OBJECT CLASS	Discretionary Amounts	Non-Discretionary Amounts	1986
Personal Services	$352,896	$3,325 2/	$356,221
Travel	6,620		6,620
Trans. of Things	1,020		1,020
Rents, Comm. & Utilities		80,404	80,404
Printing & Repro.	3,955		3,955
Other Services	37,499		37,499
Supplies & Materials	5,567		5,567
Equipment	7,140		7,140
Total	$414,697 1/	$83,729	$498,426

1/ Most of the non-payroll costs are required for delivery of services to veterans or unavoidable administrative payments such as state approval agencies costs.

OBJECT CLASS	Discretionary Amounts	Non-Discretionary Amounts	1987
Personal Services	$356,774	$3,653 2/	360,427
Travel	6,466		6,466
Trans. of Things	1,020		1,020
Rents, Comm. & Utilities		81,930	81,930
Printing & Repro.	4,000		4,000
Other Services	51,828		51,828
Supplies & Materials	5,600		5,600
Equipment	12,064		12,064
Total	$437,752 1/	$85,583	$523,335

2/ This amount includes terminal leave, cash awards, and SES bonus.

The funds by object class are described in the 1987 General Operating Expenses section of the President's Budget.

The sequestration by object class is shown in the following table:

OBJECT CLASS	1986	Gramm-Rudman	1986 Current Estimate
Personal Services	$356,221	($13,677)	$342,544
Travel	6,620	(800)	5,820
Trans. of Things	1,020		1,020
Rents, Comm. & Utilities	80,404		80,404
Printing & Repro.	3,955	(1,217)	2,738
Other Services	37,499	(1,199)	36,300
Supplies & Materials	5,567	(2,200)	3,367
Equipment	7,140	(2,000)	5,140
Total	$498,426	($21,093)	$477,333

The below table reflects the changes from 1986 to 1987:

OBJECT CLASS	1986	1987	Increases/ Decreases
Personal Services	$342,544	$360,427	$17,883
Travel	5,820	6,466	646
Trans. of Things	1,020	1,020	0
Rents, Comm. & Utilities	80,404	81,930	1,526
Printing & Repro.	2,738	4,000	1,262
Other Services	36,300	51,828	15,528
Supplies & Materials	3,367	5,600	2,233
Equipment	5,140	12,064	6,924
Total	$477,333	$523,335	$46,002

The transfer from the Office of Data Management and Telecommunications increases the 1987 personal services.

As a result of the Gramm-Rudman-Hollings reductions, the 1986 amounts are below current service levels. The increases in printing and reproduction, and supplies and materials in 1987 will enable the Department to meet normal operation requirements.

The increase in rents, communications and utilities is primarly due to higher rental charges, and the target maintenance contract will increase the other services. Equipment increases reflects resources for the modernization requirements.

Question: 1. List the amount of discretionary funds available in DM&S and DVB, by account, what these funds are used for, how they are affected by the FY 1986 sequester and FY 1987 budget proposal. Be sure to include printing, travel and training.

Answer: All DM&S funds are discretionary. The sequesteration of funds will reduce obligations in areas that will least impact operations. The following chart by DM&S account reflects the FY 1986 sequester and the FY 1987 budget proposal:

APPROPRIATION

	FY 1986 pre-GRH		Change		FY 1986 After-GRH		FY 1987 Budget Proposal	
	FTEE	$	FTEE	$	FTEE	$	FTEE	$
Medical Care.	193,941	$9,247,694	-1,306	$-117,557	192,635	$9,130,137	185,093	$9,083,983
M&P Research.	4,388	189,265	-20	- 8,138	4,368	181,127	4,266	188,915
MAMOE........	678	53,524	-14	- 2,302	664	51,222	591	42,[illegible]4
Grants for Const of State Ext. Care Facil..	...	21,758	...	- 936	...	20,822	...	42,400
Grants to Phillipine..	...	495	...	- 21	...	474	...	500
Canteen Ser. 1/ Rev. fund...	3,530	190,414	...	- 8,104	3,530	182,310	3,530	193,537
Therapeutic 1/ Rehab Fund...	...	2,325	...	- 100	...	2,225	...	2,350
Gen Post 2/	...	13,500	...	...		13,500	...	14,500
Total DM&S..	202,537	$9,718,975	1,340	$-137,158	201,197	$9,581,817	193,480	$9,568,379

1/ Obligations for non-appropriated activities

2/ The General Post Fund is dependent upon private donations and was not sequestered

RESEARCH

Question: 1. A) In what way will you use the increased staffing requested for rehabilitation research?

Answer: The increase of 20 FTEE in the FY 87 budget is planned to be used for Rehab R&D projects in the following priority areas:

Prosthetics/Amputation/Orthotics	8 FTEE
Spinal Cord Injury	7 FTEE
Sensory Aids	5 FTEE

Question 1. B) Provide a three-year breakdown of individual project costs, scope, goal, salaries of project employees and report of results for rehabilitation research. Include names of grant recipients.

Answer: Attached are reports on each current Rehab R&D project that provide the information requested.

Development of Improved Sockets and Fitting Procedures for Artificial Limbs
AIZCORBE, OSCAR R., M.D. 658 SALEM, VA
PROJECT 1
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Wilson, AB

PROSTHETICS, AMPUTEES, FLEXIBLE SOCKETS, THERMOPLASTICS, GAIT ANALYSIS, ENERGY EXPENDITURE, REHABILITATION, ADJUSTABLE SOCKETS

Objectives: The purposes of this project are: (1) to develop more comfortable sockets for lower-limb amputees by the use of flexible brims, (2) to develop an objective method of evaluating the effectiveness of the experimental prostheses by determining over extended periods energy indices and activity levels, and (3) to design and develop custom fitted adjustable sockets for use with patients with newly acquired amputations in order to reduce rehabilitation time and costs.

Research Plan: A design of the sockets with flexible brims has been fitted to three below-knee amputees with satisfactory results from the patients' viewpoint and is ready for more extensive trials. The equipment needed to record, process, and display heart beats and steps against time is ready for use in evaluating the effectiveness of the experimental sockets. A prototype of an adjustable socket has been designed and one socket has been tried on a seasoned amputee. The results are encouraging and trials with new amputees are scheduled to begin at an early date.

Methods: Data collection forms are being developed to gather subjective information on subject perception of comfort. Objective testing will be conducted in a gait analysis laboratory involving techniques using videotape recording, locomotion assessment mat, step counters, physiological cost index determinations, and the amputee assessment and activity form.

Results to Date: The socket with flexible brims is ready for trial. A manual for fabrication of the sockets has been started. The ambulatory monitoring equipment is ready for final testing a prototype adjustable socket has been designed and one unit has been fabricated.

	Total Funding	Personnel Services
F/83	$-0-	#-0-
F/84	$53,163	-0-
F/85	142,382	#6,138

Development of Improved Sockets and Fitting Procedures for Artificial Limbs
PUNYANITYA, VISEPONG, M.D. 658 SALEM, VA
PROJECT 1
LAST REPORT, FINAL 12/84

ASSOCIATES: Aizcorbe, OR Wilson, AB

PROSTHETICS, AMPUTEES, FLEXIBLE SOCKETS, THERMOPLASTICS, GAIT ANALYSIS, ENERGY EXPENDITURE, REHABILITATION, ADJUSTABLE SOCKETS

Objectives: The purpose of the project is to improve the comfort and function of lower-limb amputees by developing better methods of fitting lower-limb prostheses.

Research Plan: Lower-limb amputees will be selected to receive prototype sockets with walls of tapering stiffness in an attempt to achieve maximum comfort. In addition, investigation will be initiated into the development of an adjustable socket that will conform to volumetric changes occurring in the stumps. Thermoplastics will be used in the development of these prototype sockets. Data is to be collected and analyzed by comparing results obtained in the six-month period immediately proceding the introduction of the experimental designs. An instructional manual useful in training prosthetists and a training course will result from the project.

Methods: Data collection forms will be developed to gather subjective information on subject perception of comfort. Objective testing will be conducted in a gait analysis laboratory involving techniques using videotape recording, locomotion assessment mat, step counters, physiological cost index determinations, and the amputee assessment and activity form.

Results to Date: The clinical aspects of the project have not been initiated as of this date.

Late loosening in total joint replacements in the lower extremities.
BAHNIUK, EUGENE, Ph.D. 541 CLEVELAND, OH
PROJECT 1
LAST REPORT, FINAL 07/84

ASSOCIATES: McLaughlin, TC

IMPLANTS, HIP, KNEE, IMPLANT FAILURE, MOTION, RADIOGRAPHY, IN VIVO MEASUREMENTS

Objective: The objective of this study is to measure and document in vivo motion of the cement bone interface in total hip and total knee replacements.

Plan: Patients with total joint replacements are studied immediately post-operative and six-month intervals thereafter.

Methodology: In volunteer subjects requiring total joint replacements, four spherical markers are inserted in cortical bone near the implant and three to six markers are imbedded in the implant cement. A biplane x-ray technique is used to measure the distance between the cement markers and the bone reference markers. Weight bearing and non-weight bearing x-rays are taken post-op and two, four, six twelve, eighteen and twenty-four months post-op.

Findings: Of a total of 68 patients who volunteered for this study, data was obtained from 54 patients. (A) The incidence of measured reversible displacement (75%) is greater than the incidence of clinical loosening (9.6% in this series). (B) One half the patients had measurable reversible displacement when measured two weeks post operatively.

Clinical Relationship: From this study it is concluded that biplane radiography is a useful clinical technique.

F.Y '83	F.Y '84	F.Y '85
$47,107	$41,397	-0-

The amount of private sector dollars provided in support of the project is as follows

F.Y 83 - $13,064
F.Y 84 - $34,557

Electrical Stimulation of Osteogenesis Using Selected Techniques

BARANCWSKI, THOMAS J., JR., Ph.D. 508 DECATUR, GA
PROJECT 2
LAST REPORT, INITIAL 08/85

ASSOCIATES: Spector, M Roberson, J

Electrical Stimulation; Electromagnetic Stimulation;
Direct Current Stimulation; Osteogenesis; Bone; Rabbit

The overall goal of this project is to determine an effective stimulation technique to be employed in research planned to evaluate the appropriateness of electrical stimulation therapy to remobilize patients with loose prosthetic devices (trauma and irritation present) and patietns with osteopenia (trauma and irritation absent). The specific aims are to [1] define the dose response relationship in magnetic field amplitude for electromagnetic stimulation (EMS) produced by a sinusoidal waveform; [2] determine whether trauma and irritation are required with EMS produced by either a sinusoidal or a square-pulse burst waveform; and [3] compare the efficacy of direct current stimulation (DCS), EMS by a sinusoidal waveform, and EMS by a square-pulse burst waveform in the same animal model. Throughout this project, the tissue site selected for electrical treatment will be the rabbit tibial medullary canal. Three sets of studies will be performed. For each study, the biological response will be evaluated by histomorphometry of new bone formation, necrotic tissue, and selected cell types within medullary canal tissue. Twelve animals will be employed for each group listed below.

A. Dose Response Relationship In Magnetic Field Amplitude For Sinusoidal EMS

Group 1: After 1 wk. of acclimation, each animal will undergo bilateral intramedullary rod insertion and implantation surgery, heal for 4 wks., sustain 3 wks. of unilateral sinusoidal EMS treatment, and then be terminated. Group 2 and 3: As in Group 1 but with sinusodial EMS of different amplitudes.

B. Necessity Of Trauma And Irritation With EMS By Sinusoidal Waveform Or Square-Pulse Burst Waveform

Group 4: After 1 wk. of acclimation, each animal will undergo unilateral intramedullary rod insertion and implantation surgery, heal of 4 wks., sustain 3 wks. of unilateral treatment with optimal sinusoidal EMS found in A above, and then be terminated. Group 5: As in Group 4 but with square-pulse burst EMS.

C. Efficacy of Three,. Different Electrical Stimulation Techniques In The Same Animal Model

Group 6: After 1 wk. of acclimation, each animal will undergo bilateral intramedullary rod insertion and implantation surgery, heal for 4 wks., sustain 3 wks. of bilateral treatment with optimal sinusoidal EMS versus DCS, and then be terminated. Group 7: As in Group 6 but with DCS versus square-pulse burst EMS. Group 8: As in Group 6 but with optimal sinusoidal EMS versus square-pulse burst EMS.

Major items of equipment include surgical instruments, EMS and DCS devices,

	Total Funding	Personnel Svc.
83	$-0-	$-0-
84	-0-	-0-
85	$9,685	$10,900

BARANOWSKI, THOMAS J., JR., Ph.D. 508 DECATUR, GA
PROJECT 2

electrical test instruments, tissue processing equipment, and a microscope plus morphologic analyzer.

LANGUAGE PROCESSING ABILITIES IN TRANSCORTICAL SENSORY APHASIA

BASILI-ZONAK, ANNAMARIA G., Ph.D. 566 FORT HOWARD, MD
PROJECT 7
LAST REPORT, FINAL 11/84

ASSOCIATES: Berndt, RS Caramazza, A

Transcortical Sensory Aphasia, Syntactic Processing, Semantic Processing
Objective of Project: To investigate the point at which linguistic processing breaks down in a single transcortical sensory aphasic subject.
Research Plan: Tasks involving several levels of auditory processing and repetition skills were designed to determine if the symptoms exhibited were a result of a selective deficit of a single processing mechanism.
Methodology: Various language tasks had been employed to supplement those developed previously. The patient has been evaluated at regular intervals over the past year to determine whether any changes in his condition have occured.
Findings, results and conclusions: Results have remained consistent over all testing: the patient's ability to repeat and to correct various sentence structures indicated a striking preservation of phonological and syntactic structures. However, his ability to process semantic information at the single-word level is severely impaired as indicated by change-level performance on word-picture matching with semantic distractors, semantic categorization tasks (with both pictures and words), synonym judgements, and tasks in which he is asked to make judgements about the properties of objects. There was clear disassociation of repetition from comprehension. Repetition was not an acoustic echobox, but was affected by the to-be-repeated materials. Repetition appears unrelated to semantic factors but sensitive to lexical or syntactic factors. Based on lexical processing tasks, phonological analysis of auditory information allowed for extraction of lexical information (but performance was not sensitive to semantic factors). This case points out the dissociation between the syntactic and semantic system. Although the syntactic system remains intact, a partial disruption in the central interpretive system produces the type of performance described above.
To date little has been understood about the nature of the linguistic capabilities of the transcortical sensory aphasic subject. It is anticipated that this study will clarify the deficits so that appropriate treatment tasks could be designed.

FY'83 FY'84 FY'85
-0- -0- -0

FEB 20, 1986 VETERANS ADMINISTRATION PAGE 1
RESEARCH AND DEVELOPMENT INFORMATION SYSTEM
REHABILITATION R&D RESEARCH PROJECTS FY 1983

Development of a Communication and Control Aid using Electromagnetic Tracking Technology
BERNAT, JAMES L., M.D. 405 WHITE RIVER JUNCTION, VT
PROJECT 2
LAST REPORT, PROGRESS 02/84

ASSOCIATES: Vanderheiden, G Krieg, JC Schneider, MR

SPASYN-COM, COMMUNICATION AID, CLINICAL EVALUATION

The referenced project is a developmental effort by a team of engineers at Polhemus Navigation Sciences and clinicians at Trace R&D Center, University of Wisconsin, to apply electromagnetic measurement and microprocessor technology to the communication problems of the nonvocal severely handicapped. The objective is to develop a new direct selection input device, capable of significantly improving present rates of communication.

In the last year, Phase II of the project was begun and all preparatory work was completed prior to beginning of clinical testing of hardware developed in Phase I. This work included the development of video exercises, automatic data collection algorithms, and protocols for selecting testees.

In January, 1984, pilot testing was conducted at the Illinois State Hospital School and Rehabilitation Center in Chicago. This site was chosen by the Trace Center as a testing site because it houses a large and diverse population of children who possess varying degrees of head pointing skills. Pilot testing enabled us to refine hardware and test procedures that will be employed in clinical evaluation of SPASYN-COM and the Long range Optical Pen -- the two candidate head pointing techniques under consideration in this project.

Pilot testing proved that both techniques can readily be employed by severely handicapped users. After its completion, we were able to schedule dates for the clinical evaluation, which will be conducted with 20 subjects during the month of February, 1984. Phase II work will end with the tabulation of test results and the preparation by the Trace Center of an engineering analysis of the merits of the two head pointing techniques.

F.Y'83	F.Y'84	F.Y'85
$57,222	$14,305	-0-

Salaries of project employees not available for F.Y'83.
For F.Y'84, $14,305 was [illegible] in government dollars
and not in personnel services.

Efficacy of Remote Tel-Communicology Delivery of Aphasia Treatment
BESS, JOHN C., Ph.D. 546 MIAMI, FL
PROJECT 1
LAST REPORT, PROGRESS 07/85

APHASIA TREATMENT; COMPUTERIZED TREATMENT; TEL-COMMUNICOLOGY; TREATMENT DELIVERY OF APHASIA, REMATE

OBJECTIVES: The purpose of this project is to compare the efficacy of two methods of delivery of an aphasia treatment program; 1) Remote Tel-Communicology, involving both clinician-telephonic and computer-assisted-telephonic delivery, and 2) Face-to-Face in medical center, delivery of the same program.

RESEARCH PLAN: Four Veteran Administration Medical Centers are serving as treatment centers in this controlled clinical trail. Patients selected at the four facilities are required to meet stringent entry criteria and are randomly assigned to one of two treatment groups: Group I: Subjects receive 24 weeks of individual face-to-face language treatment. Group II: Subjects receive 24 weeks of individual language treatment delivered by Tel-Communicology methods at their usual living environments.

METHODS: A complete battery of tests of communicative abilities are administered to each subject upon entrance into the 24 week treatment project with selected measures readministered at eight week intervals thereafter.

RESULTS: (Present status) 803 patients were screened; 18 have been accepted as study subjects. Of those, 13 have completed the 24 weeks of treatment. Nine of the subjects who completed the 24 week study period were retained for continued treatment with retresting conducted at 12 week intervals. Data obtained from these subjects will be analyzed to determine the influence of structured language treatment upon communication ability of chronic aphasics.

	Total Funding	Personnel Services
83	$68,342	$64,562
84	$95,178	$87,278
85	$90,910	$90,910

Incorporated with the [illegible] Study

Automated Fabrication of Lower Extremity Prosthetic Sockets
BLOCKER, WILLIAM P., M.D. 580 HOUSTON, TX
PROJECT 4
LAST REPORT, PROGRESS 07/85

ASSOCIATES: KKrouskop, TA

CAD/CAM, PROSTHETICS, ULTRASOUND

This project is designed to evaluate the feasibility of using computer aided design and computer aided manufacturing (CAD/CAM) technology to fabricate sockets for lower extremity prostheses.

The project is based on the premise that by employing a finite element computer code which uses data that characterize the shape of the non-loaded residual limb and the mechanical stiffness of the tissue, it is possible to generate the shape that the socket should have in order to effectively transfer the body weight through the soft tissue and thus minimize tissue trauma and user discomfort.

During the course of the work two new pieces of instrumentation have been developed and reduced to clinical prototypes. The first system is an automated shape sensor that can characterize the surface topography of the amputee's residual limb to an accuracy of +/- 0.01 inches. The second instrument is a pulsed doppler ultrasonic system that uses the sound to measure the motion of points in the tissue when the tissue is subjected to a cyclic forcing function. The motion data are then used to calculate the elastic modulus of the tissue.

To date these instruments have been used to collect information on one above knee amputee and a socket has been fabricated using the CAD/CAM system. The fit of the socket is currently being evaluated. If it is satisfactory, e.g. the amputee uses the socket regularly, sockets for an additional 8-10 amputees will be fabricated and evaluated.

	Total Funding	Personal Services
F.Y83	-0-	-0-
F.Y84	$129,211	$118,150
F.Y85	$175,754	$1,000

Cognitive Rehabilitation in Right Hemisphere Stroke Patients

BOBBITT, ROBERT G., Ph.D. 626 NASHVILLE, TN
PROJECT 1
LAST REPORT, FINAL 11/85

COGNITIVE REHABILITATION; STROKE PATIENTS; INSTRUMENTAL ENRICHMENT

Objective: The effectiveness of a cognitive education program will be investigated as a rehabilitation tool in the cognitive retraining of right hemisphere stroke patients.

Plan & Method: In an ABA design, the 5 experimental and 5 matched control subjects will be thoroughly evaluated in pre and post treatment assessment using traditional psychological and neuropsychological instruments as well as a dynamic assessment of problem solving introduced by Feuerstein et al (Learning Potential Assessment Device, 1979). Only the experimental group will receive cognitive training. In group instruction twice each week for ten weeks, the restraining will involve paper and pencil worksheets and teacher mediation in the manner introduced by Feuerstein et al (1980) as Instrumental Enrichment.

Findings: The primary issue in the evaluation of data for this project was to identify the presence of any systematic individual change as a function of IE training. Both group and individual statistical analyses were used. The dependent measures were selected to reflect: 1) task specific change i.e. Mastery Tests and 2) generalized change i.e. Wechsler Adult Intelligence Scale-Revised (WAIS-R). Halstead-Reitan Battery (HRB), Minnesota Multiphasic Personality Inventory (MMPI), LPAD. This project showed that the Experimental subjects who received IE training significantly outperformed the Control subjects on tasks specific measures. Thus, subjects who received even a very brief exposure to IE outperformed their matched control subjects on tasks that required the same cognitive strategies, but were at a more advanced level (Mastery Tests). There was no significant difference between groups on any of the pretraining measures of generalized change. Only two of the 58 comparisons demonstrated a significant scale 3, and 2) RSDT-1 time, one of the LPAD measures. In both instances the measures increased from pretraining to posttraining which would be in the opposite direction predicted.

To summarize, the evidence is convincing for a difference between groups as a function of IE training on task specific measures. There is no evidence that the effects of IE training extend to more generalized measures of cognitive, behavioral and personality dimensions. The lack of findings for the generalized measures could be attributed to: 1) length of IE training was insufficient, 2) size of the sample was too small, and/or 3) observed effects of IE appeared to be largely motivational.

	Total Funding	Personnel Services
F/83	-0-	-0-
F/84	$22,938	$9,424
F/85	-0-	-0-

FACTORS AFFECTING REGENERATION AND RECOVERY AFTER CERVICAL CORD INJURY

BOHLMAN, HENRY H., M.D. 541 CLEVELAND, OH
PROJECT 3
LAST REPORT, FINAL 04/85

ASSOCIATES: Bahniuk, E

recovery, incomplete, spinal cord injury

OBJECTIVES: The objective of this research is to measure non-invasively in the animal model and man the degree of spinal cord damage and the effect of various factors on recovery of the injured spinal cord; and we hope to predict which spinal cord injury will and which will not recover after surgical decompression.

PLAN: To study cortical evoked potentials in both the animal model and the spinal cord injured patients.

METHOD: Our current method of spinal cord monitoring utilizes computer averaged cortical evoked potentials which travel through the ascending posterior columns after stimulation of a peripheral nerve. We have found that 50% decrease in amplitude of the evoked potentials indicate severe spinal cord damage which may or may not revcover.

FINDINGS: A pressure of 15 PSI on the vervical spinal cord produces an incomplete quadriplegic dog which will not recover unless pressure is relieved. It has been determined in 51 animals that the kinetic energy necessary to permanently produce a partial spinal cord injury by weight drop averages 800 gm cm. Pathologic findings in the cervical cords of both animal models include central grey matter necrosis to varying degrees and demyelinization of the white matter. We have studied histologic specimans of the spinal cords by light microscopy and these reveal central grey necrosis in 24, "V" shaped hemorrhages and edema of the dorsal columns in 15, anterior corticospinal tract degeneration in 11, and gliosis and demyelinization of the lateral corticospinal tracts in 10.

CLINICAL RELATIONSHIP: This pathologic analysis indicates a very characteristic "V" shaped demyelinization of dorsal colulmns depending on the age of the lesion, the vulnerable central grey matter as well as Wallerian degeneration in the anterior corticospinal tracts. The CEP alteration may be related to damage of the posterior tracts which is observed.

	Total Funding	Renewal [illegible]
83-	# 70,639	N/A
84-	-0-	-0-
85-	-0-	-0-

Development of Environmental Control Units for Disabled Veterans

BRESLER, MARK I., M.S. 635 OKLAHOMA CITY, OK
PROJECT 1
LAST REPORT, INITIAL 09/85

Environmental control; remote control

A large population of elderly veterans and civilian population are confined to a single room, such as an extended care hospital or nursing homes. Many people in this situation need help in simple tasks such as operating lights, T.V.s, radios, beds and other appliances. An "environmental control" would allow them to perform these tasks themselves rather than having to call for assistance.

The Electronic Industries Association (EIA) has a task group developing standards allowing remote control of lights and appliances within a room for the able bodied. If these standards are implemented, this would allow equipment from different manufactures to work together.

This project will research the desirability from both a technical and economic viewpoint of using these emergining specifications in an extended care facility. If these components can be used, system cost can be minimized, because only a controller usable by the handicapped would need to be designed.

	Total Funding	Personnel Svcs
	#	#
83-	-0-	-0-
84-	-0-	-0-
85-	#12,000	#9,000

Unistik Vehicle Controller for Severly Disabled Veterans

BRITELL, CATHERINE, M.D. 554 DENVER, CO
PROJECT 2
LAST REPORT, INITIAL 02/85

ASSOCIATES: Johnson, DR Ciciora, J

Functional motor vehicle control for tetraplegics above the C6 level or people with only one functioning extremity has been heretofore only very limitedly feasible, difficult to obtain, and exceedingly costly. The Unistik Vehicle Controller (UVC) was developed by Johnson Engineering Corporation in conjunction with and supported by the National Aeronautics and Space Administration and the Veterans Administration. It consists of (a) the driver interface, a complex joystick mechanism which translates the driver's control movements into electronic signals, (b) the signal controller, which processes and modifies the signals from the driver interface and sends them to the vehicle interface, and (c) the vehicle interface, electromechanical actuators which move and position the steering shaft, brake pedal, and accelerator pedal in response to the electronic control signals. Characteristics of the joystick control, including sensitivity, centering, feedback, or other qualities, may be modified by altering software in the signal controller, thus providing reversible adaptation to individual patient needs. The UVC system is easy to control with one hand, light-weight, safe, reliable, easy to install, and can be adapted to a wife range of physical disabilities. Ongoing development, supported by the Rehabilitation Research and Development Program of the Veterans Administration, will include further refinement of the signal control systems, development of secondary controls, reliability and safety evaluation, and testing and modification for various physical disabilities. The UVC system represents a potentially highly functional solution to the problem of vehicle control for severely handicapped people.

	Funding Total	Professional Services
83	-0-	-0-
84	281,226	2,962
85	150,000	-0-

Ocular Controlled Communication for Disabled Veterans.
BRITELL, CATHERINE, M.D. 554 DENVER, CO
PROJECT 1
LAST REPORT, PROGRESS 11/84

ASSOCIATES: Rinard, G

The purpose of this project is to further develop and refine an existing ocular-controlled communication system and to explore the feasibility of using this system for environmental control for very severly disabled patients, particularly those with severe brainstem dysfunction.

A device was developed, fabricated, and tested with a second patient at the Denver VA Medical Center, using a 3-position Morse-Code encoding system and interfacing with a video terminal with memory, dot-matrix printer, orthographic vocal encoder, and simple switching mechanisms for environmental control.

Written communication was developed to a rate of 18 characters per minute over a 3-week traning period. Environmental control functions of bed positioning and TV tuning were evaluated. Because of necessity of frequent re-positioning of the patient for these functions, these are not considered feasible.

Further development is planned to improve the mechanical stability, simplicity, and reliability of the eyeglass system, with the goal of more closely approaching a simple, inexpensive unit suitable for production and delivery to patients.

FY'83	FY'84	FY'85
$62,367	$460	$287,188

The amount of personnel service dollars provided in support of this study is by year

FY'83 - 0
FY'84 - 0
FY'85 - $2962

Clinical and Laboratory Study of Amputation Surgery and Rehabilitation
BURGESS, ERNEST M., M.D. 663 SEATTLE, WA
PROJECT 1
LAST REPORT, PROGRESS 04/85

RESEARCH PROSTHETICS, LIMB VIABILITY, AMPUTEE REHABILITATION
Objective of the Project: 1. To design, develop, evaluate and transfer this research technology to appropriate sources for distribution to handicapped veterans. 2. To investigate the viability and healing potential of tissues, particularly skin in ischemic limbs, for the purpose of improving levels of amputation, surgical techniques and post-surgical amputee rehabilitation.
Research Plan and Accomplishments: 1. Engineering and functional response on the VA SEATTLE energy storing/releasing prosthetic foot has led to a standardized design. 500 feet have been distributed to designated veterans throughout a nation-wide network of VA Medical Centers. Tracking data accrual are being carried out by the Evaluation and Development Section, Rehabilitation R&D, VA Central Office, Washington D.C. Field testing of these 500 feet indicate overwhelming acceptance of this appliance. It is being released for national commercial distribution with priority to veterans. Continuing research will provide refinements. Reseach in Energy Prosthetics has been extended for the development of a lower limb prosthetic shank incorporaing physiological force/motion. Desired function for this component is incorporated in the design and in the materials, not in individual mechanical segments. 2. The Limb Viability Research Unit has met at weekly intervals at PRS Center. Transcutaneous oxymetry and other objective data are correlated with clinical findings to improve clinical judgement in amputations for ischemia. Laser Doppler velocimetry has been reincorporated into the protocol. The collaborative biological structure studies of ischemic skin being conducted in cooperation with Drs. Olerud and Odland continues to actively harvest microwounds on patients whose limbs come to amputation for ischemia at VAMC Seattle. A volunteer control subset has been investigated. Organ culture of ischemic skin samples indicates a survival time of up to 40 days. This research effort is probing basic biological phenomena regarding skin wound healing. The clinical relevance of this information is evident. The veteran population who can benefit from this knowledge is large and increasing.

	TOTAL	[illegible]
F/ 83	$248,062	- N/A
F/ 84	$341,387	- $19,873
F/ 85	300,762	$26,500

Design Stress Analysis of Porous Ingrowth Hip Replacements
CARTER, DENNIS, Ph.D. 640 PALO ALTO, CA
PROJECT 2
LAST REPORT, INITIAL 04/85

design concepts, porous ingrowth, femoral, acetabular, prosthesis

The objective of this study is to develop design concept for porous ingrowth femoral and acetabular artificial hip components based upon a knowledge of the stress fields in the hip before and after joint arthroplasty. The goal is to produce guidelines for the manufacture and implantation of a new generation of hip replacement components which require less bone removal and can be successfully implanted in younger patients. The impact of this research upon the disabled will ultimately be a reduction in the incidence of hip prosthesis loosening. This loosening is a serious problem since it can lead to failure of the prosthesis. Much of the loosening problem is hypothesized to be due to improper stress transfer across the prosthesis bone interface. This research will determine the stress patterns and provide design criteria and suggestions which should provide the basis for improved prosthesis design.

Anatomical specimens will be sectioned, x-rayed, and photographed to document geometry, distribution of bone density, and trabecular orientations. From these sections, 2-D and 3-D finite elements models of the acetabulum and proximal femur will be generated. Similar models with various porous implant components in place will also be constructed. These models will incorporate the option to solve non-linear, contact problems at the joint surface and at any or all implant/bone interfaces. In this manner, the stresses in the implants, bone and across interfaces can be determined under loading conditions which simulate at initial implantation and after partial or complete ingrowth has been achieved. Parametric studies will determine the effects of assumed boundary conditions, load magnitude and direction, inplant geometry, and implant and bone material properties.

	Total Funding	Personnel Service
	$	$
83-	-0-	-0-
84	-0-	-0-
85	$ 50,950	$ 40,450

Development of Upper-Limb Prostheses
CHILDRESS, DUDLEY S., Ph.D. 535 CHICAGO, (LAKESIDE), IL
PROJECT 2
LAST REPORT, INITIAL 07/84

UPPER-LIMB, PROSTHESES, PREHENSION

This program of development work concerns new arm and prehension systems for upper-limb amputees. In the human system, the arm is subservient to the hand. The arm operates almost subconsciously to place the hand in appropriate locations for prehension or other function. We are developing position servo-mechanisms for above-elbow amputees. Experimental investigations indicate these mechanisms will provide superior control compared with other controls that have been used clinically. This control approach permits some degree of subconscious control of arm motion because it uses, to some extent, the body's own motor, sensory, and proprioceptive mechanisms in the control loops. The objective of this proposal is to make this arm controller practical for clinical applications and to integrate it with powered joints to equip VA amputees with smoothly operating, well coordinated arms that do not require a lot of attention or training to operate.

An upper-limb prosthesis depends upon the terminal element for prehension. Therefore, good prehensile devices are necessary for successful function. Our second objective is the development of several new prehensile systems, based around a new power unit that has resulted from previous VARR&D support. Three new prehensile systems will be developed and clinically tested. They are: (1) a new "prehensor," (2) a new powered hand (cosmetic) and, (3) a new "utility" hand.

	Total Financing	Personnel Service
83	-0-	-0-
84	$ 12,600	-0-
85	$ 236,040	$ 23,250

Prosthetics Research Study.
CHILDRESS, DUDLEY S., Ph.D. 535 CHICAGO, (LAKESIDE), IL
PROJECT 1
LAST REPORT, FINAL 04/85

ASSOCIATES: Thompson, RG Grahn, EC

PROGRESS REPORT

(1) Myoelectric Hook - We have made contact with Hosmer Dorrance Corp. concerning the commercial development of this system. They are enthusiastic about the project and will cooperate with the development. The electronic control system has been changed to CMOS technology to reduce quiescent power to insignificant levels. This has enabled us to power the hood with two 9V transistor batteries, which reduce size, weight, and cost and which provide a battery easily available to the public. Also a Hall-effect current cut-off circuit is being designed to limit stall current. The project is on schedule.

(2) Multifunctional Arm - A Ph.D. dissertation on this topic has been completed by Dr. James A. Doubler. The title is "An Analysis of Extended Physiological Proprioception As A Control Technique for Upper-Extremity Prostheses". Two papers on this work have been prepared for the Bulletin of Prosthetics Research. Work is now centered on development of sensors and controllers suitable for use outside the laboratory. Hall-effect strain transducers and buckle transducers (strain gage) are being tested for suitability.

(3) A/E Prosthesis - The lifting mechanism for the cable-driven above-elbow prosthesis has been redesigned and is available for testing. We have asked Hosmer Dorrance to evaluate the new version.

(4) Below-Knee Demonstration Project - Seventy below knee amputees have been fitted with the new technique and data is being gathered.

(5) Hip-disarticulation Prosthesis - An M.S. thesis has been completed by Mr. Robery Van Vorhis on this topic. The thesis is titled "Pendular Models of the Swing Phase During Gait: The Canadian-Type Total Limb Prosthesis". A paper is in preparation. These studies are ongoing and the results are published.

F.Y'83	F.Y'84	F.Y'86
$185,000	$255,000	$236,040

The amount of funds provided for salaries for each of the above fiscal years is as follows

F.Y'83 - 0
F.Y'84 - 0
F.Y'85 - $23,250

Stimulation of Repair of Cortical Bone Transplants by Implantation of Piezoelectric Materials: Development Study
COCHRAN, GEORGE VAN B., M.D. 533 CASTLE POINT, NY
PROJECT 5
LAST REPORT, PROGRESS 07/85

ASSOCIATES: Williams, W Johnson, M Dempster, D
Lee, BY

Bone Stimulation, Internal Fixation, Piezoelectric

Objectives of the Project: To develop a new approach to electrical stimulation of bone healing based on design of a "less-rigid", internal fixation plate incorporating a piezoelectric material to generate electric currents during physiologic loading.

Research Plan: We are evaluating two approaches to design of internal fixation plates incorporating piezoelectric materials. In Type I a piezoelectric ceramic or polymer is attached to the underside of the plate and is in direct contact with bone. In Type II, a piezoelectric ceramic is sealed within the plate; the current output is delivered to bone by electrodes.

Methodology: Tests have been conducted with both designs using miniature piezoelectric internal fixation plates (36 x 6 x 1.5mm) attached to beagle radius, ulna and femur. Effects of the Type I plates have been studied by histological observations on drill holes or osteotomies beneath the active piezoelectric surface. Type II plates have been studied by measuring output during in vitro loading, and during actual walking in vivo using beagles. Output also has been measured during excitation with external ultrasound.

Results: Tests of Type I plates have failed to demonstrate any direct action of piezoelectric materials on bone formation. Tests with Type II plates have been successful in generating significant currents in vivo. In beagles, following rectification of plate output, average direct currents of 0.2-0.4uA have been generated during walking and currents exceeding 50uA have been generated by external ultrasonic energy (10mw/cm[supra 2]) applied to the skin.

Clinical Significance: Tests of piezoelectrically generated currents on bone formation in rabbits are in progress as are design studies on larger (human scale, Type II) piezoelectric plates for tests in large animals. This new type of orthopaedic implant could add an important resource in prevention and treatment of non union.

F/'83	F/'84	F/'85
$53,780	$81,278	$57,079

The amount of [illegible] dollars [illegible] of this project as follows

F/83 - not available
F/'84 - $16,823
F/'85 - $19,983

Biomechanics of Bone Resorption/Regeneration at a Bone-Implant Interface
COCHRAN, GEORGE VAN B., M.D. 533 CASTLE POINT, NY
PROJECT 4
LAST REPORT, PROGRESS 08/85

ASSOCIATES: Brunski, J - Dempster, D

Bone remodeling, resorption, regeneration, internal fixation

Objective: To clarify understanding of bone remodeling in relation to the biomechanical conditions at an implant-bone interface, as a step toward quantitation of "Wolff's Law" as it pertains to implants.

Plan: The proposed research will attack the problem with the aid of a model involving both trabecular and cortical bone of dogs. Via specially shaped stress devices and controlled application of loads, interfacial bone will be subjected to known states of stress for a one week period, to be followed by analysis of interfacial bone activity in response to the dynamic mechanical environment.

Methodology: The stress devices (which resemble screw-type dental implants) are implanted into trabecular bone of dog mandibles, and cortical bone of dog radii, and remain load free for 3 months. Programmed loads then are applied to the stress devices by a computer controlled loading device, and interfacial mechanics calculated by finite element stress analyses. Bone activity is documented by tetracycline labeling and related histomorphometry.

Findings and Results: Loading regimens have been completed on 6 loaded and 6 control screw implants in beagle radii as well as on 6 T-shaped mandibular implants in 6 other dogs. Undecalcified bone sectioning has been completed on all tissue specimens and histomorphometric analysis of results is currently in progress using both normal light as well as flourochrome techniques. Results to be completed within the final year. 3-D finite element analysis of stress on the implants has highlighted interfacial bonding as a major factor in stress prediction but further work will be required to define the status of this factor in our experimental model.

FY'83	FY'84	FY'85
$96.000	$81,873	$55,201

The amount of personnel service dollars provided in support of this project are as follows

FY'83 - 0
FY'84 - 0
FY'85 - $42,419

A Feasibility Study on Detection of Impending Pressure Sores Using Ultrasound
COCHRAN, GEORGE VAN B., M.D. 533 CASTLE POINT, NY
PROJECT 6
LAST REPORT, INITIAL 11/84

ASSOCIATES: Kadaba, MP Ferguson-Pell, MW Lee, BY

ULTRASONIC, PRESSURE SORES, EARLY PREDICTION OR DETECTION

Objectives of the Project: The objectives of this study shall be to develop ultrasonic techniques to assess the state of superficial and deep tissues with respect to early changes which signal the incipient development of tissue breakdown as well as changes during the healing process.

Methodology: The proposed research will approach the problem by means of an experimental model in pigs already established by the applicant team. Tissue damage in pigs is created by applying a constant force through specially shaped indentors under the control of a microprocessor. This model will be employed to create a known degree of tissue damage on which specific acoustic parameters can be measured for comparison to normal. Acoustic parameters, namely, attenuation and integrated backscatter, will be measured over normal and pressure damaged tissue or regions utilizing an ultrasonic pulse echo system. An IBM instrumentation computer will be used for acquiring and processing ultrasonic data. Reflected ultrasonic data will be sampled at 50 MHz using a Biomation 8100 A/D converter. Correlation of acoustic parameters with histology of pressure damaged tissues will lay the ground work for future development of a routine non-invasive, clinical, ultrasonic test which could warn of impending pressure sores and whether the changes were occurring in deep or superficial tissues.

Significance: Clinical problems associated with the effects of mechanical pressure on soft tissue represent one of the great challenges in the management of handicapped individuals. Due to the high cost of care and management of patients with pressure sores, it is important to gain further understanding of their etiology, and to develop techniques that permit early prediction or detection of impending tissue breakdown in time to take corrective action. Prediction of risk from pressure sores is based on measurement of external factors (such as interface pressure), but predictions are unreliable within tissue. Furthermore, external measurements do not monitor the actual state of the tissues, yet patients each may react differently to similar environmental conditions. Detection of incipient pressure sores implies some direct means of measuring the actual condition of the tissues. This study is designed to investigate the feasibility of utilizing ultrasonic techniques for this purpose, with special reference to deep tissues.

	Total Funding	Personnel [illegible]
83 -	-0-	-0-
84 -	$ -0-	-0-
85 -	73760	$ 14,000

Implant Fixation by Post-Insertion Pressurization of Polymethylmethacrylate

CONVERY, F. RICHARD, M.D. 664 SAN DIEGO, CA
PROJECT 1
LAST REPORT, PROGRESS 01/85

ASSOCIATES: Woo, SLY

BONE CEMENT, PRESSURIZAITONS OF BONE CEMENT, CANINE TOTAL KNEE

Objectives: To determine the cement viscosity and pressure which when sustained would be most suitable for human application.
Methods: Paired six-inch segments from the proximal femur of human cadavers were potted and placed in an especially designed jig. Zimmer LVC and Howemdica Simplex P were injected into the specimens under pressures of 20, 40, 60, and 80 psi. The pressure was maintained until an advanced dough-stage was reached that precluded maintenance of a longer period of pressurization. Four quadrant specimens from 10mm thick cross sections taken from the proximal and distal portions of the specimen were tested for shear strength. Depth of penetration was determined by partial digestion of cross sections in HCl acid which were photographed and projected onto a digitizing screen.
Results: Pressures up to 60 psi could be sustained. Pressures greater than 60 psi could not be sustained because of leakage of the cement through the lined aspera and cortical defects, especially in osteoperotic bone. There was a serial increase in interfacial shear strength up to 60 psi with both Simplex and LVC. Cement penetration to the corticocancellous border was achieved at all pressures and by both cements but cortical penetration was significantly greater with LVC. Despite the increased corticol penetration achieved with LVC, an increase in interfacial shear strength was not demonstrated as compared to Simplex P at equivalent pressures.
A canine total knee has been designed to assess the local and systemic toxicity of the above techniques. Initial procedures have been complicated by patellar dislocation which has been prevented by proper rotation of the tibial component. Once this problem was corrected, functional use has been achieved for a long as three months.

	Total Funding	Personnel Svcs
83-	-0-	-0-
84-	$113,271	$28,488
85-	$90,179	$40,271

The Mechanical Properties of Porous Coated Orthopaedic Alloy
COOK, STEPHEN D., Ph.D. 629 NEW ORLEANS, LA
PROJECT 3
LAST REPORT, PROGRESS 04/85

ASSOCIATES: Thongpreda, N Anderson, R

Porous coating, Endurance limit, Ti-6Al-4V, Heat Treatments

The porous metal coating applied to a solid substrate has been shown, in vivo to offer advantages over current methods of implant fixation. However, these advantages may be lost in devices requiring a sintering heat treatment to apply the porous coating. In our studies to date, uncoated Ti-6Al-4V orthopaedic alloy was found to have an endurance limit of 605 MN/m(supra 2). The application of a porous coating decreased the endurance limit by approximately 77%, and when the uncoated substrate material was heat treated to the same temperature as the porous coated samples a degradation of approximately 34% was observed. The difference being the porous coating acting as a notch.

The reduction of fatigue properties by the heat treatment is due to the transition from the as-received equiaxed microstructure to the lamellar structure upon sintering. This lamellar structure has been shown to have inferior fatigue properties related to the equiaxed structure. In the present study, microstructural analysis was performed on three different post sintering heat treatments of Ti-6Al-4V in an attempt to improve the fatigue properties. The heat treatments investigated provide microstructures somewhat different from the original sintering heat treatament. Thus, these heat treatments may help in resistance to crack initiation and propagation during the cyclic loading of porous Ti-6Al-4V orthopaedic devices and thus result in improved fatigue properties.

The resulting microstructures obtained from the heat treatments were lamellar, coarse acicular, and fine acicular. Mechanical properties such as yield strength, ultimate tensile strength, percent elongation, and hardness were investigated and compared to those of the as-received equiaxed structure. As expected, the equiaxed structure exhibited the best properties: yield strength of 965 MPa, ultimate tensile strength of 1140 MPa, elongation of 13.50 percent, and Rockwell Hardness C of 32.90; whereas the lamellar structure produced the poorest properties: yield strength of 824 MPa, ultimate tensile strength of 954 MPa, elongation of 5.10 percent, and Rockwell Hardness C of 26.20. The scicular microstructures displayed mechanical properties which ranged between those of the equiaxed and lamellar structure. Overall, the fine acicular structure was stronger than the coarse acicular structure.

FY'83 - $0 -	Not avail.
FY'84 - $48,416	$24,622
FY'85 - $242,604	$187,386
Funding allocation	Personal Services

Orthopaedic Implant Retrieval & Analysis
COOK, STEPHEN D., Ph.D. 629 NEW ORLEANS, LA
PROJECT 1
LAST REPORT, PROGRESS 04/85

ASSOCIATES: Kester, M Harding, A Thomas, K

Stainless steel, bone plates, corrosion, metallurgical examination

The implant retrieval and analysis research program continues to collect orthopaedic hardware from VA affiliated medical centers. To date, 5235 patient records have been accumulated. During 1984, 656 devices were inserted in the 4 VA affiliated hospital & 220 implants were removed routinely or due to cause-related reasons.

Presently, the clinical performance, corrosion characteristics & metallurgical properties of retrieved femoral & total knee prostheses are being evaluatated. These properties have recently been examined in 82 retrieved bone plates which were in situ for periods of 1-169 monts. Fifty-one of the 82 plates were removed for cause-related reasons, while only 24 were removed on a routine basis. (The removal reasons for 7 plates were unknown). Stereomicroscopic examination revealed that over 89% of the recovered implants displayed some degree of pitting, crevice and/or fretting corrosion. Statistical analysis revealed that metallurgical properties correlated significantly with all types of corrosion. This evaluation suggested revision of current ASTM standards to improve the corrosion resistance of orthopaedic implants.

Other recently completed studies evaluated the clinical performance & metallurgical characteristics of retrieved hip plate devices & intramedullary rods. The 61 hip plates studied included 2 commonly used designs: the Jewett nail-plate and the Richards screw-plate. These devices were in situ for 2-156 months, yet only 10% were removed on a routine basis. Our data suggested that surgeons consider these devices to be permanent implants, with removal undertaken only for causative factors. No statistically significant differences were found between the metallurgical & corrosion properties of the two designs studied, however 4 devices of each design were out of ASTM specification. Also, 4 of the Jewett devices fractured in situ.

Similar evaluations were made on 16 A-O intramedullary rods. Cracking and/or fracture was observed in 4 of the 16 rods. This study revealed that structural & material characteristics were responsible for implant mechanical failures, thus warranting improvements in fabrication techniques. Also, our data suggested careful assessment of painful IM rod and routine removal after fracture healing.

A clinical analysis of 28 retrieved Harrington rods has also been completed. Fifteen rods fractured in situ, yet our data revealed that material defects were probably not contributory to the implant failure. Emphasis on attention to surgical detail in order to obtain early graft healing & solid hook placement was suggested.

Funding Allocation	Personal Services
F/'83 $- 93,455	— Not avail.
F/'84 $- 188,627	$146,246
F/'85 $- 33 862	$ 28,309

Microwave Myelography: A Feasibility Analysis

CROWGEY, SCOTT R., M.D. 508 DECATUR, GA
PROJECT 2
LAST REPORT, INITIAL 06/85

ASSOCIATES: Sharpe, S

Myelography, Microwave Imaging, Microwave Continuous-Wave Techniques, Microwave Reflection Techniques, Spinal Cord Injuries, Subarachnoid Space

A means for non-invasively imaging the spinal cord and subarachnoid space would be a marked improvement over the currenlty used invasive forms of myelography for the evaluation and follow-up of spinal cord injuries resulting from trauma or degenerative disease. Although the bony protection provided by the vertebrae prohibit the use of X-rays or ultrasound for this type of imaging, the intervening bone would not be as great a barrier to the use of microwaves in this region of the body. This project will evaluate the feasibility of using both wide-band continuous-wave techniques and impedance-sensitive reflection techniques for the two-dimensional microwave mapping of the spinal subarachnoid space. This investigation will primarily involve the analysis of relevant literature based on the results of a literature search and patent search. Based on this initial analysis, an experimental protocol will be developed to further establish the feasibility of this approach for application to non-invasive myelography. It is anticipated that these efforts will then serve as a basis for the preparation of a larger proposal which will better support the investigational equipment and time required for completed evaluation.

	Total Funding	Personnel Services
83	-0-	-0-
84	-0-	-0-
85	$9,737	-0-

External and Internal Stabilization of the Disrupted Cervical Spine

CSONGRADI, JOHN J., M.D. 640 PALO ALTO, CA
PROJECT 1
LAST REPORT, PROGRESS 05/85

ASSOCIATES: Perkash, I Whalen, R

CERVICAL SPINE, SPINE FIXATION, INTERNAL FIXATION

PROGRESS REPORT THROUGH APRIL 1985: The objective of this program is to develop a methodology for analysis of spinal motion with controlled loading and to apply this methodology to two types of cervical spine stabilization, interspinous wiring and a segmental wiring technique.

Investigation of the internal fixation techniques for cervical spine stabilization utilizes a six degree of freedom motion transducer in the intact and disrupted spine in fresh human cadaver material. Feasibility of the motion analysis system was tested using three intact human cadavers. Since that time isolated fresh cervical spine specimens have been tested using the motion transducer and controlled loading applied by a servohydraulic mechanical testing system. Continuous motion and force data have been collected to provide force displacement characteristics for axial rotation, lateral bending, flexion and extension.

In the first phase of actual testing, now complete, the two stabilization techniques mentioned above were tested and compared with the motion of the intact spine. The intact spines were noted to be significantly stiffer in axial rotation than in flexion extension or lateral bending. The disrupted spine fixed with interspinous wiring was significantly stiffer than the intact spine in flexion extension but significantly less stiff in axial rotation and lateral bending.

At the present time a prototype for a new spinal fixation system has been developed and is under test utilizing the same analysis system. Results of this study will be utilized to select the most appropriate stabilization for selected cervical spine injuries.

Results of the first phase of the program have been presented to the Orthopedic Research Society & will be published in orthopedic transactions.

	Personnel Svcs
F/'83 - $ 43,915	$32,915
F/'84 - $ 47,429	$19,630
F/'85 - $ 39,105	$26,000

NERVE-BUNDLE CONDUCTION VELOCITY DISTRIBUTIONS - CLINICAL RESEARCH APPLICATIONS

CUMMINS, KENNETH L., Ph.D. 640 PALO ALTO, CA
PROJECT 1
LAST REPORT, FINAL 08/83

ASSOCIATES: Dorfman, LJ Leifer, LJ

Our objective in this work was the development and application of sensitive non-invasive electrophysiologic techniques for the study of nerve function. In general, only a small subpopulation of the largest nerve fibers are characterized by current methods. Our approach is to estimate the contribution to the compound (motor or mixed motor/sensory) action potential from nerve fibers conducting at different velocities. The resulting histogram is the electrophysiologic counterpart of the histologic fiber-diameter distribution, and is referred to as the distribution of conduction velocities (DCV). Our clinical studies (40 normal subjects and 30 patients with diabetes) have shown that DCV analysis provides a reliable measure of nerve-bundle conduction characteristics that may detect subtle nerve abnormality even when conventional electrophysiologic techniques yield normal findings.

We have recently completed a study comparing three computer-based methods for estimating the DCV of myelinated fibers in the median nerve of humans. Features of the DCVs (Maximum CV, mean CV, peak CV, and range) obtained using the two motor-DCV methods were very similar, but all of these parameters were significantly higher (p less than .001) for the mixed-nerve (motor and sensory) method. This difference presumably represents the properties of the faster-conducting sensory fiber population included in the mixed-nerve analysis.

Progress is also being made toward the development of a stand-alone system for estimating DCVs that does not require a general-purpose computer. We have succeeded in implementing the mixed-nerve DCV algorithm on a Nicolet Instrument Corporation 1280 processor in the Nicolet Pathfinder II system. We are currently working to integrate this algorithm into the software package for the Pathfinder II, in order to render DCV analysis more accessable to the clinical diagnostic community.

This project has terminated under Dr. Cummins, as Dr. Cummins has left the facility. Dr. Leslie Dorfman will continue the study as Principal Investigator.

FY'83 - [illegible]-0-

FY'84 - 0-

FY'85 - 0-

The Use of the Electroretinogram to Predict Retinal Cell Activity

DAVEY, KENT R., Ph.D. 508 DECATUR, GA
PROJECT 1
LAST REPORT, INITIAL 08/84

ASSOCIATES: Allen, RC Kelly, GW

ELECTRORETINOGRAM, RETINAL, SALINE

The measurement of an electrical potential in response to retinal illumination, i.e., Electroretinogram (ERG), has been a qualitatively useful diagnostic techniue in ophthalmology for several years. We are proposing an extension of the diagnostic capability of the ERG to predict activity over small sections of the retina. The concept involves translating an electrical potential plot over the cornea into a retinal membrane current source density profile.

The goals of the project are to develop a quantitative diagnostic procedure for determining localized retinal activity. The clinical ERG will be the springboard for the effort -- the authors propose to refine the ERG methodology to provide a potential scan across the cornea. This scan will then be used to predict the location of small areas of the retina responsible for the readings. This objective will be achieved in three stages:

(a) design and construction of a spherical saline cavity with sources dispersed over one hemisphere and electrodes over the other, where the electrodes simulate the realization of the corneal scan eventually achieved by a multielectrode lens.
(b) interfacing this potential scan measurement to a 6502 microprocessor through an A-D convertor: and
(c) computing the matrix representation and inversion using the same microprocessor to predict source activity in the retina.

	Total Funding	Personnel Services
FY83	$-0-	-0-
FY84	$5,200	-0-
FY85	$71,493	$8,689

FEB 20, 1986 VETERANS ADMINISTRATION PAGE 1
RESEARCH AND DEVELOPMENT INFORMATION SYSTEM
REHABILITATION R&D RESEARCH FY 1984

Programmable, Implantable 22-channel nerve stimulator for Paraplegia
DAVIS, ROSS, M.D. 402 TOGUS, ME
PROJECT 3
LAST REPORT, PROGRESS 12/84

ASSOCIATES: Adams, M Miller, G

PARAPLEGIA; SPINAL CORD INJURY; IMPLANTABLE PROGRAMMABLE NERVE STIMULATOR; SPASTICITY; BLADDER NERVE STIMULATOR.

OBJECTIVE: To stimulate multiple nerves in the pelvis and lower extremities of paraplegic patients in programmable patterns resulting in the modes of exercise, standing, walking, stair-climbing and bladder function.

RESEARCH PLAN: A series of four paraplegic patients will be chosen who are healthy, informed and agreeable. These patients have had a spinal cord injury above the vertebral levels of T9-10 and still have intact nerve roots and reflexes to ladder and lower extremities but no longer under voluntary control. The Nucleus 22-channel nerve stimulator (Nucleus Crop. - Telectronics, Englewood, Colorado) will be implanted in the subcutaneous tissues of the lower abdomen. The 22 lads will be corrected to 20 motor and sensory nerves of each lower extremity (10 leads to each) and 2 leads to the bladder nerve roots (S(sub-3)). The implanted stimulator will receive coded radiofrequency transmitted signals and power via an antenna from the external control unit. The control unit will select one or more stimulating channels into activity from set programs designated for: (1) exericse of a limb or joint; (2) standing; (3) walking by step timing; (4) climbing stairs and (5) bladder contractions to urinate.

METHODOLOGY: The Nucleus-Telectronic 22-channel stimulator will be modified for the above five functions, by considerable computer programming. The external stimulating unit has EPROM chips for memory programming, a further memory module will be added to define the five functional programs.

RESULTS: The Nucleus Company has supplied the 22-channel stimulator December 1984. Dr. Eckhouse and Dr. Davis will be testing this equipment in rabbits in January 1985. Dr. Davis will be gaining experience with the device by visiting the manufacturers for one week in December 1984. Drs. Herman and Maulucci will start the study of two normal subjects for analyzing gait to be transformed into mathematical data for the computer program.

	Funding Total	Personnel Svc
F/83	-0-	$ -0-
F/84	$ 9,000	$ -0-
F/85	$ 21,530	$ -0-

Clinical Application Study of Training Techniques and Devices for the Blind

DE L'AUNE, WILLIAM R., Ph.D. 689 WEST HAVEN, CT
PROJECT 2
LAST REPORT, INITIAL 12/84

ASSOCIATES: Geruschat, D

Evaluation, Rehabilitation, Visual Impairment, Prosthetics

At the present time there is no universally accepted evaluation procedure in the performance of orientation and mobility by the blind or partially sighted. This has serious implications in terms of programs and device evaluation as well as documentation of patient progress. To address some of these concerns, the NIHR is currently supporting the development of an orientation and mobility evaluation protocol at the Pennsylvania College of Optometry (PCO) R&D Center. The investigators in this project, through cooperative efforts between the Veterans Administration's Eastern Blind Rehabilitation Center (EBRC) and PCO, have been actively involved with the development of this protocol. The system has been fully implemented and is now in use at PCO.

While the population sample at PCO is large and potentially representative of the visually impaired population of the United States, there are basic differences related to gender, visual history and secondary conditions between this population and that served by the VA. This project seeks to adapt the O&M evaluatory protocol to accommodate these perceived differences and to integrate and extend the number of subjects' scores contained in a cummulative data base.

	Total Funding	Personnel Services
	$	$
83	-0-	-0-
84	-0-	$ -0-
85	$9204	2879

Technology for Psychiatric Rehabilitation
DONAHOE, CLYDE P., Ph.D. 530 WEST LOS ANGELES (BRENTWOOD DIV
PROJECT 1209
LAST REPORT, INITIAL 09/85

TECHNOLOGY FOR PSYCHIATRIC REHABILITATION

Proposal for Problem Solving Training Module

Purpose

This is a proposal for constructing a validated, systematic package for training veterans with psychiatric disorders how to cope effectively with difficult interpersonal situations. The package will consist of a high-quality videotape and associated therapist and patient manuals for use in inpatient and outpatient mental health settings. The materials will be of sufficient detail and structure to permit both professional or paraprofessional health service therapists to deliver the training. The materials will be tested to ensure its efficacy, validity, and reliability of administration.

	Total Funding	Personal Services
83	$ -0-	-0-
84	$ -0-	-0-
85	$ 9,453	3500

Experimental Analysis of Training and Generalization of Syntax
DOYLE, PATRICK 645 PITTSBURGH, (HD), PA
PROJECT 1
LAST REPORT, INITIAL 07/85

Generalization, syntax, Aphasia

OBJECTIVES: The long term objectives of this project are to provide empirically derived intervention data that can be used to evaluate the efficacy and efficiency of Helm's Elicited Language Program for Syntax Stimulation (HELPSS) in treating aphasic patients with language impairments.

RESEARCH PLAN: Aphasic subjects from the Highland Drive VA Medical Center Speech Pathology Program as well as five other cooperating facilities in the Pittsburgh area are evaluated using the Boston Diagnostic Aphasia Exam and the Western Aphasia Battery; only patients classified as Broca's aphasics according to these test instruments are considered potential subjects. Inclusionary criteria include; 1) at least six months post onset of left hemisphere CVA, 2) native English speaker, 3) average auditory activity no worse than 25dB htl, 4) no history of psychiatric illness or alcoholism, 5) no severe verbal dyspraxia, 6) no severe dysarthria, and 7) must not be receiving other speech or language training.

METHODOLOGY: Subjects are evaluated before and after HELPSS training using: The Western Aphasia Battery, the Aphasia Comprehension Test for Syntax, and the Northwestern Syntax Screening Test. Baseline measurement of specific HELPSS sentence types is conducted; subjects enter training at the sentence level which elicits a consistently low and stable level of responding. The treatment programs lasts approximately 3-4 months and is conducted on a daily basis during 30-45 minutes sessions. Generalization to novel examples of the trained sentence types is assessed at regular intervals within the multiple baseline design of this study.

RESULTS TO DATE: To date, two subjects have completed the program. These results are reported in Clinical Aphasiology (In Press). Currently, five additional patients have been evaluated for inclusion in this study; two of these qualified and are being seen on a regular basis. Another six potential subjects have been identified by cooperating agencies and will be evaluated in the next two months. These results are providing the empirical evidence necessary to develop a more effective and efficient technology of intervention for acquired aphasia.

	Total Funding	Personnel Service
83	$ -0-	$ -0-
84	-0-	-0-
85	$ 9,283	$ 6,265

Development, Testing and Evaluation of Prosthetic Devices/Training of Prosthetics
EFFENEY, DAVID J., M.D. 662 SAN FRANCISCO, CA
PROJECT 2
LAST REPORT, FINAL 04/85

ASSOCIATES: Skinner, HB

PROSTHETIC FOOT FUNCTION ARTICULATED PROSTHETIC FOOT TRAINING OF PROSTHETISTS PRESCRIPTION STANDARDS PROSTHETIC RESEARCH
PROJECT OBJECTIVES: This project has four major objectives. (1) To define prosthetic foot function and develop prescription standards for prosthetic feet. (2) To develop a light weight off-the-shelf prosthesis requiring fabrication of only the socket. (3) To develop and refine the design of a new articulated prosthetic foot. (4) The fourth objective is to provide training in prosthetic research for certified prosthestists.
RESEARCH PLAN: Determination of standards of foot function in the below-knee amputee and the development of prescription criteria to achieve these standards. Engineering development and refinement of the new prosthetic devices.
CLINICAL APPLICATION: The aim is to provide improved lower extremity prosthesis for the veteran amputee and to train a future generation of prosthetists in research methodology..
Note (4/85):
(Dr. Effeney has transfered to another station).
Dr. Skinner has taken over this project.

	Total Funding	Personnel Services
83	$ 45,773	$ 44680
84	$ 195,940	155,356
85	$ 50,066	$ 43,600

SMOKING AND ATHEROSCLEROSIS (A) THE EFFECT OF SMOKE COMPONENTS ON PLATELET FUNCTION
EFFENEY, DAVID J., M.D. 662 SAN FRANCISCO, CA
PROJECT 1
LAST REPORT, FINAL 03/84

SMOKING, ATHEROSCLEROSIS, NICOTINE, CARBON MONOXIDE, PROSTACYCLIN PRODUCTION

Project Objectives: The objectives of this research were to determine the effects of nicotine (N) on platelet function, and catecholamine release in man: to examine the effects of pretreatment with N and carbon monoxide (CO) alone and in combination on the ability of the heart to produce prostacyclin and to examinq the effects of N on the work performed by the isolated perfused rabbit in the ventricular septum and to correlate the work performed with prostacyclin production.

Research Plan: Platelet function and catecholamine release was studied in man during 60 minute infusions of normal saline and N 1.5 mg/Kg. N concentrations were measured using gas liquid chromatography platelet catecholamine concentrations were measured with radio-enxymatic technique and platelet function studies were performed using a modification of the turbimetric method of Born. A model was developed in the rabbit which allowed prolonged infusion of N with simultaneous exposure to CO. The effect of these two treatment modalities alone and in combination were studied on the ability of the heart to produce prostacyclin. The isolated perfused rabbit inventricular septal model modified by Raffa was used to examine the effects of N on the work performed by the heart. Biological activity of prostacyclin was assessed by the ability to inhibit ADP induced platelet aggregation and 6 keto PGF-1-alpha radioimmunoassay.

Results: At levels of circulating N equivalent to that obtained from smoking in some human subjects the platelet count falls sharply. There was hyperaggreability to ADP and epinephrine which has been confirmed in some animals. We have shown a reduction in prostacyclin production by various chambers of the heart after pretreatment with N and an increase in prostacyclin production after a weeks pretreatment with CO or when CO and N were administered together. We have shown that N was widely distributed in animal tissues and that N was concentrated in the aorta and in the heart to levels 2 to 3 times that found in the circulating blood. These studies are important in helping to establish the pathogenesis of atherosclerosis and the relationship of smoking to its initiation and continued development.

	TOTAL	Personal Serv
FY - 83	$45,773	$44,680
FY - 84	$195,940	$165,856
FY - 85	$50,066	$43,600

Development of a Digital Hearing Aid and Fitting Procedure
ENGEBRETSON, A. MAYNARD, D.Sc. 674 TEMPLE, TX
PROJECT 857
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Morley, RE Popelka, GR Niemoeller, AF

DIGITAL HEARING AID, MICROPROCESSORS, HEARING ASSESSMENT, HEARING-AID FITTING, SIGNAL PROCESSING

The purpose of this project is to develop a digital hearing aid and a companion fitting procedure that will improve the precision and flexibility of fit that can be achieved with hearing aids. Towards this goal, special laboratory-based systems have been assembled to evaluate the overall concept. These systems include: 1) a digital hearing aid breadboard (DHAB) and 2) a computer-based audiometer system. The DHAB includes an ear-level module that contains a signal and probe microphone and two hearing-aid receivers. All four input ad output channels can be sampled at a 50 kHz rate and have a dynamic range of 96 dB. Distortion in each channel is less than -80 dB of full scale. The arithmetic capacity of the DHAB is 15 million multiply-add operations per second.

Application programs have been written for the DHAB to simulate, in real time, a four-channel instantaneous compression hearing aid. The input encoding can be changed from linear PCM to companded PCM over different dynamic ranges to evaluate these parameters with regard to speech recognition experiments with hearing-impaired subjects. In addition, programs have been written for the computer-based audiometer that measure the patient's residual hearing, that program the digital hearing aid, and that test the patient's residual hearing, that program the digital hearing aid, and that test the patient's ability to recognize sounds of speech. This allows us to evaluate the fitting procedure of tailoring the gain and maximum power output of the aid in a frequency dependent way to conform to the patient's range of threshold, most comfortable listening level, and uncomfortable listening level. Preliminary results with 21 patients indicate that the new testing procedures are accurate and efficient. The automated procedure requires 15 minutes as compared with the use of traditional clinical methods and conventional hearing aids that require upwards of three hours.

Preliminary design of the wearable version of the digital hearing aid that will be fabricated during this next year is nearly finished. The wearable unit will be pocket sized and have a battery life of about 10 hours.

A preliminary study of the power consumption and size requirements of VLSI (very large scale integrated) circuitary suitable for hearing aid signal processing has been complted. Assuming a feature size of 1-micrometer and a power supply of 1.5 volts, the area of a VLSI chip containing 400 9-bit logarithmic multiplier-accumulator cells arranged in a systolic array would be about 49 square millimeters (7 mm on a side) and power consumption would be about 0.6 milliwatts. This structure is sufficient for implementing the four-channel hearing aid algorithm and appears to satisfy the requirements of low power and small size required for an ear level

Total Funding Research Service

83 -	$14,000	-0-
84 -	$189,981	-0-
85 -	189,362	$4,000

ENGEBRETSON, A. MAYNARD, D.Sc. 674 TEMPLE, TX
PROJECT 857

version of the digital hearing aid.

Rehabilitation Research, Evaluation, and Learning Laboratory (RREALL)
ENGLEHARDT, KAREN G. 640 PALO ALTO, CA
PROJECT 2
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Perkash, I Leifer, LJ

REHABITITATION RESEARCH, EVALUATION, LEARNING, COMPUTER-ASSISTED INSTRUCTION (EDUCATION) PROTOTYPE RESEARCH AND INTERACTIVE EVALUATION, PRE-VOCATIONAL ASSESSMENT

OBJECTIVES: Design and develop a modular learning and evaluation laboratory (RREALL) composed of three stations: 1) module for evaluations of new devices (such as robotic acids) and their interfaces; 2) learning evaluation module providing computerized interactive education on 24 hour basis to disabled patients, their families, and allied health care professionals; 3) module for assessing pre-vocational training potentials and experience.

METHODOLOGY: Interactive Evaluation Methodology.

RESEARCH PLAN: was modified due to equipment acquisition delays; however, work has proceeded with existing, available equipment.

FINDINGS: Robot/interface research progress: (module 1): development and interactive evaluation of an artifical vision application for facilitating easier use of the robotic aid; mathematical formulation of Interactive Evaluation Model showing potential cost savings achievable; forthcoming publication of voice-control robot research in the Journal of the Human Factors Society; publication of voice-control robot research in the Journal of the American Voice Input/Output Society; pilot testing of Locus of Control questionnaires; The Ultrasonic Head Control Unit integration with the robotic aid has been postponed.
Interactive Education research progress (module 2): Control Data Corporation's educational materials and training station ordered; written manual for instruction on the robotic aid revised and readied for inclusion in an interactive educational program; beta testing of computer-assisted instruction authoring system from Kent State (O.S.E sponsored); have begun developing programs to voice guide user onto system and into computer menus which direct the user to various learning modules. Prevoctional assessment research progress (module 3): after seven months delay in equipment delivery, IBM pcAT set-up with voice recogniton keyboard; software for hands-off questionnaire completion is under development; addition of computerized job-matching system evaluated and ordered.

IMPLICATIONS & RELEVANCE: These baseline research findings have increased the field's understanding of severely disabled individuals' potential use of robotic technology to increase their overall independence.

	Total Funding	Personnel Services
83	-0-	-0-
84	-0-	-0-
85	68,800	-0-

Development of the ISNY Flexible Socket System for Below-Knee Amputees
FISHMAN, SIDNEY, Ph.D. 630 NEW YORK, NY
PROJECT 1
LAST REPORT, INITIAL 09/84

ASSOCIATES: Gustav, R

The purpose of this project is to extend the application of the Icelandic-Swedish-New York University (ISNY) Socket System, successfully applied to the above-knee patient, to all below-knee amputation levels, including the syme. The central ISNY concept relates to the provision of two fundamental socket functions, "weight transmission" and "hydrostatic containment," by two separate structures rather than by a single, rigid structure as in the present plastic laminate socket. In the ISNY system, containment is accomplished by a thin, light, flexible, polyethylene socket; while weight transmission is provided by an abbreviated, carbon-fiber-reinforced, laminated frame. This system has produced expressions of a dramatic enthusiasm from many hundreds of above-knee patients. In attempting to apply this unique concept to below-knee amputation levels, the primary problem relates to the design of the weight-transmitting frame. Sequentially stated, the research objectives are: Design and Development of: 1. A frame for below-knee sockets with cuff suspension. 2. Frame variations for sockets that incorporate alternative suspension methods (the supracondylar variants and thigh-lacer/side joints). 3. Frame to accommodate the special features of the Syme residual limb (end-bearing potential, distal bulbous shape and the problem of comfortable donning and doffing). In order to attain these objectives, a number of patient fittings are necessary to obtain clinical reactions and to finally validate design concepts. Material and Fabrication Research: Concurrent with the above, to carry out a program of testing and research relating to the materials and fabrication procedures utilized in the ISNY weight-bearing frame. The goals here are increased strength and rigidity, decreased weight as well as simpler and safer fabrication procedures. It is our hope and intention that this project will provide the below-knee amputee the same significant advantages as have been afforded the above-knee patient.

	Total Funding	Personnel Services
F/83	-0-	-0-
F/84	-0-	-0-
F/85	$91,314	-0-

Volume Changes Occuring in Postoperative Below the Knee Stumps
GOLBRANSON, FRANK L., M.D. 664 SAN DIEGO, CA
PROJECT 5
LAST REPORT, FINAL 01/85

Stump Volume, Stump Circumference, Stump Maturation Rate, Stabilization Point, Stump Reduction, B-K Amputee

OBJECTIVES: 1) Evaluate three different stump volume reduction methods, 2) establish means to determine point of stabilization in the stump maturation process, 3) determine whether circumferential measures can be used reliably to define the point of stabilization, and 4) determine whether life of the first permanent prosthesis is extended by using the point of stabilization as the criterion for the time to make the prosthesis.

RESEARCH PLAN: Test 20 patients in each of three categories of stump reduction method: 1) elastic wrap, 2) plaster cast and pylon, and 3) lined laminate plastic socket and pylon.

METHODS: Use water displacement method in a specially designed device, measure stump volume weekly until stabilization is reached. At each test session, measure circumferences at 2, 4, and 6 inches from the distal aspect. Make same measurements bimonthly for the duration of the first permanent prosthesis. Use statistical and mathematical means to determine stabilization. Correlate circumference and volume. Compare performances among categories.

RESULTS TO DATE: The study was completed. Nearly 80 patient were enrolled in the project; over half discontinued for various reasons; final data treatment included 36 patients, approximately equally distributed among the three categories. Diversity in physical health significantly influenced how both stump volume and circumference varied with time, resulting in no clear trends; linear regression was more effective overall than special curve fitting methods. The plastic laminate showed the fastest stump maturation rate. Circumference is a valid means to monitor stump maturation. Effects of health status resulted in an inability to satisfactorily characterize a stabilization point by either volume or circumference change. A conservative choice in time to fit the first permanent prosthesis resulted in more comfort to the patient and significantly extended its useful life.

	Total Funding	Personnel Svcs
83	$27,793	N/A
84	$9,806	$8,050
85	$10,346	$7,234

Foot Interface Pressure Study
GOLBRANSON, FRANK L., M.D. 664 SAN DIEGO, CA
PROJECT 6
LAST REPORT, PROGRESS 01/85

PLANTAR ULCER, PLANTAR PRESSURES, PRESSURE REDISTRIBUTION, INSOLE MATERIALS

OBJECTIVES: 1) Develop a pressure distribution registration method for selecting interface materials, 2) determine physical characteristics of interface materials appropriate for prescription criteria, and 3) develop a methodology to evaluate the efficacy of pressure redistribution quantities of interface materials.

RESEARCH PLAN: Patients presenting at VAMC with established findings of peripheral neuropathy, diabetic or non-diabetic, with decreased foot sensation will be selected for the study. Patients will be seen at appropriate intervals to record changes in status and progress in healing. Interface materials will be tested for physical characteristics and other factors impacting on suitability for use.

METHODS: Note patient weight, health status, and ambulatory habits. Map vibratory perception thresholds on the foot and leg among normals and patients. Attempt to determine an "at risk" boundary among patients. Obtain plantar barograms as deemed appropriate. Periodically measure dimensions of ulcers to note rate of change. Use total contact casts to unload severe ulcer areas during ambulation. Use heat molded foam plastic insoles to redistribute pressures on plantar surface. Determine effects of time-related and nontime-related properties of materials to clinical prescription requirements. Collect insoles after 50 percent compression set occurs during use in foot wear. Relate physical properties of materials used to clinical results. Determine what techniques and combinations of materials offer better treatment.

RESULTS TO DATE: Method of treatment influences success in patient care. For the not "at risk" patients, unmolded, small-cell, foamed polyethylene insoles are satisfactory. Issuing four sets for daily change allows recovery from compression set. The "at risk" patients require two-stage treatment: the case during ulcer healing followed by thick heat molded insoles and sandals while scar tissue matures. Dimensional data has been gathered on 80 used insoles of varibus materials to relate to patient characrteristics including ambulatory habits.

	Total Funding	Personnel Svcs
83	$13,800	$ N/A
84	13,148	$ 11,984
85	12,517	$ 11,117

The Effect on Gait Using Various Ankle-Foot Devices
GOLBRANSON, FRANK L., M.D. 664 SAN DIEGO, CA
PROJECT 8
LAST REPORT, INITIAL 08/85

Prosthetic Foot-Ankle, BK Foot-Ankle, Foot-Ankle Prescription, Foot-Ankle Gait

OBJECTIVES: Determine: 1) prescription criteria for foot-ankle assemblies, 2) what bearing stump length has on choice of foot-ankle assemblies, 3) whether walking at different speeds and on unlevel surfaces help make choices in foot-ankle assemblies, and 4) whether selected objective gait measurements can be used effectively in the alignment and adjustment of foot-ankle assemblies.

RESEARCH PLAN: Laboratory locomotion test 20 unilateral below-knee amputees, 35 to 75 years of age, using five different foot-ankle assemblies: SACH, articulated single axis, SAFE, multiaxial Gressinger, and SEATTLE.

METHODS: Test under three conditions of walking: 1) level at three speeds: "Comfortable", faster, and slower than "Comfortable," 2) ramp ascent-descent at comfortable speed, and 3) lateral incline-decline at comfortable speed. Instrumentation: bilateral heel and toe foot switches, bilateral knee electrogoniometers, accelerometer pack on prosthesis, gimbal mounted biaxial accelerometer secured to sacro-lumbar area with a snug fitting waist-hip belt, and a tachometer cord attached to the waist belt. Calculate a-p and m-l angular accelerations of the prosthesis, external work of locomotion, Fourier coefficients of wave forms, harmonic ratios; examine wave forms for deviations. Apply a variety of mathematical and statistical techniques to correlate, to determine trends, and to discriminate among different foot-ankle assemblies. Test a selected fraction of the subjects during level walking when alignments and adjustments are not optimum.

	Total Funding	Personnel Services
83	$ -0-	$ -0-
84	-0-	-0-
85	$ 28,450	$ 15,750

Analysis of Below-Knee Suspension Systems: Effect on Gait
GOLBRANSON, FRANK L., M.D. 664 SAN DIEGO, CA
PROJECT 7
LAST REPORT, PROGRESS 01/85

BK SUSPENSION, SUSPENISON CRITERIA, SUSPENSION PRESCRIPTION, SUSPENSION GAIT

OBJECTIVES: Determine: 1) Specific prescription criteria for a suspension system for a given patient, 2) effect of activity level on choice of suspension, 3) effect of stump characteristics and physical capability on choice of suspension, 4) gait variables are useful to differentiate effectiveness among suspensions, and 5) advantages and disadvantages of a given suspension system.

RESEARCH PLAN: Laboratory locomotion test 20 adult unilateral below-knee amputees, 50 to 65 years of age, using seven different suspension systems.

METHODS: Measure at three different walking speeds: knee movements with electrogoniometers, axial movement of stump in socket, gait events with foot switches, fore and aft and vertical accelerations at lumbar-sacral area, and forward velocity with a tachometer. Calculate mechanical work of locomotion; examine waveforms from electrogoniometers, tachometer, and accelerometer for deviations. Apply mathematical and statistical methods to relate variables and to discriminate among different suspension systems.

RESULTS TO DATE: Gait data was gathered and treated on 10 normals for use as biomechanic measures of amputee performance. Amputee performance can be discriminated by suspension using both mechanical work and harmonic ratios. Incidence of deviations in waveforms of knee flexion-extension, forward and vertical accelerations, and tachometer can be detected, identified, and related to suspension by patterns of anomalies. Testing and data treatment has been completed on four amputees to date.

	Total Funding	Personnel Services
83-	-0-	-0-
84-	$50,840	$29,874
85-	$55,670	$31,000

DEVELOPMENT AND EVALUATION OF A NEW ARTIFICIAL LARYNX
GOLDSTEIN, LEWIS P., Ph.D. 573 GAINESVILLE, FL
PROJECT 1
LAST REPORT, FINAL 06/83

ASSOCIATES: Rothman, HB Oliver, CC

The purpose of this project was to develop and evaluate a new artificial larynx that was cosmetically pleasing, had effective contact over a wide range of anatomical structures, could be fitted to the neck for extended periods, had a choice of activation and would be highly intelligible over a wide range of acoustic environments.

First year of effort was spent on equipment acquisition, studying acoustic and vibration characteristics of human neck tissue. Second year began work on compact oscillator. Third year consisted of developing base plate for holding vibration caps, straps and test and evaluation. Fourth year was spent optimizing output and putting in peripherals including activation, power supply and neck mounting. During the fifth year the tracheoesophageal puncture was an established procedure. Problems of coupling to variable anatomical configurations, pressure problems of neck mounting and activation problems necessitated a change of design to a hand held model. Initially the oscillatory system for neck-mounted device was used in a hand held configuration. This was changed to an enclosed direct alignment mechanism which reduced energy efficiency.

By the fifth year, it was evident that a market for such a device was no longer feasible for commercial production. That is the availability of the tracheoesophageal puncture to 75% of the laryngectomized population makes capital investiment by the commercial sector uneconomical.

FY'83	FY'84	FY'85
$7,000	-0-	-0-

FY '83 funding in personnel services not available

Early Fitting of the Amputees with a Plastic Temporary Adjustable BK Prosthesis

GOTTSCHALK, FRANK, M.D. 549 DALLAS, TX
PROJECT 1
LAST REPORT, INITIAL 07/85

ASSOCIATES: Ashford, M Gaston, J

Plastic Adjustable Prosthesis

The objective of this study is to evaluate the effectiveness of the temporary adjustable below knee prosthesis for early walking and rehabilitation of the below-knee amputee. The expected benefits are that such a prosthesis could be used at hospitals where prosthetic facilities are not available, to allow for early mobilization of the dysvascular amputee and reduce hospital stay.

The study will be done with about 40 newly amputated patients. The effectiveness of the prosthesis will be assessed objectively and subjectively. Patient tolerance as to comfort and fit will be noted. Fittings will be supervised by a qualified prosthetist. The stump will be inspected before and after donning to detect any areas of increased pressure or possible areas of skin breakdown. The maturation of the stump will be measured using Archimedes' principle of volume displacement in a fluid (sterile water) to determine how rapidly the stump shrinks. A waterproof skin marking pen will be used to mark a level on the tibial tuberosity and volume measurements will be done weekly for six weeks.

This study is designed to enhance patient care of amputees.

	Total Funding	Personnel Services
83	-0-	-0-
84	-0-	-0-
85	$8,000	-0-

Molded Shoe
GRAF, PETER M., D.P.M. 662 SAN FRANCISCO, CA
PROJECT 1
LAST REPORT, PROGRESS 04/85

ASSOCIATES: Stess, RM

THERAPEUTIC MOLDED SHOES, DIABETIC ULCERS, FOOT ULCERS, FOOT DEFORMITY, DIABETIC PERIPHERAL NEUROPATHY
Project Objectives: (10 To fabricate a molded show at markedly reduced cost (approximately $10 per pair) and significantly shorten delivery time (48 hours or less) without the loss of therapeutic effectiveness.
Plan: Utilization of foam injection technology already established in the commercial shoe industry and applying it toward the manufacture of molded shoes.
Methodology: The following three devices will be developed, tested and refined: (a) An electronic measuring instrument to accurately position the foot while it is being casted.
(b) A mechanical casting system to duplicate the foot being casted.
(c) An injection molding system and variable shaped mold.
Clinical Relationship: This area of research is highly relevant to the treatment of patients suffering from foot problems secondary to vascular disease, diabetes, deformity, arthritis and peripheral neuropathy.
Results to Date: A prototype electronic measuring device has been developed utilizing principles of ultrasound. A data base has been established from information obtained from the examination of 62 patients. Control and at-risk patient groups are being defined. The shoe design has been finalized and materials for its contruction selected. Casting techniques have been refined, a casting platform constructed and a last preparation manual has been developed.
Arrangements have been made with the 3-M Corporation in Minnesota to develop a fiberglass "tubular foot casting" system to facilitate cast-taking and cast-removal. Prototype casting materials are currently being produced by 3-M to be tested here in May. A small shoe manufacturing facility with foam injection capability has been set up to begin production of the molded shoe. Collaborative efforts have been made with the departments of Radiology and Metabolism to investigate the possibility of using modalities such as ultrasound, thermography and MRI as screening procedures for identification of the at-risk diabetic patient.

	TOTAL	Personnel Svce
FY 83	$24,504	$23,561
FY 84	$83,051	$17,700
FY 85	$84,753	$63,850

Functional Stimulation in a Simian Paraplegic Model
GROSS, CORDELL, M.D. 554 DENVER, CO
PROJECT 2
LAST REPORT, FINAL 12/84

This project was very preliminary to a proposal investigating the potential for a Canda Equina Stimulating FES system. Six dogs underwent acute laminectomy and exposure of the Canda Equina roots for patterned stimulation. Stimulation was carried out with a programmable system (Cyborg) using 4 roots on a side. Sequential powerful hip and knee extension and flexion alternating from right to left was accomplished. Creshendo/descreshendo voltage (0-3V) and frequency provided the smoothest recruitment and muscle action. The grant proposal was submitted and turned down with encouragement to resubmit.

	Total Funding	Personnel Svcs
	$	$
83-	7,400	2400
84-	15,000	-0-
85	-0-	-0-

Biomechanical Studies of Bones and Joints
HANAGUD, SATHYA V., Ph.D. 508 DECATUR, GA
PROJECT 1
LAST REPORT, INITIAL 08/84

ASSOCIATES: DeAndrade, R Clinton, RG

JOINT MECHANICS, DYNAMICS, KNEE JOINTS AND TIBIA, ACOUSTIC EMISSION

The proposed research project is in the field of biomechanics of bones and joints. A feasibility study, conducted during the past year has indicated that the results of the project have the potential of providing early diagnostic tools to detect bone and joint disorders. The objectives of the proposed project are to explore these potentials.

In particular the dynamic response (or the vibration response) of knee joints and tibia will be measured and analyzed. In the case of the knee joint, the accelerometer response and the acoustic emission output will be measured during active articulation. The response from normal knees and knees with disorders will be measured, analyzed and compared.

In the case of the tibia, the primary effort will be to identify the density distribution (or mass distribution) and the elastic properties of the bone. The tests will be conducted initially in-vitro and then in-vivo. The bone will be vibrated by using a miniature calibrated hammer or a small shaker. The measured response at several locations and a mathematical model will be used to identify the density distribution (and elastic properties of the bone). The method of identification will be based on the foundations of the structural dynamic system identification procedures. The identified density distribution and elastic properties of the bone should provide information for diagnosis of bone disorders. For example, change in density or mass distribution should provide an indication of osteoporotic conditions. All these tests are noninvasive and nontraumatic.

It is hoped that the accelerometer and acoustic information will provide a clue as to the degree and extent of arthritis, thus providing a quantitative evaluation otherwise difficult to measure. The analysis may also give clues as to the structures involved and their topology.

	Total Funding	Personnel Services
83	$ -0-	-0-
84	$ -0-	-0-
85	$ 5,000	-0-

Direct Measurement of Loudness Recruitment in Hearing-Impaired Veterans

HELLMAN, RHONA P., M.S. 750 BOSTON, OPC, MA
PROJECT 1
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Welsh, OL

HEARING LOSS, LOUDNESS RECRUITMENT, COCHLEAR PATHOLOGY, RETROCOCHLEAR PATHOLOGY, MAGNITUDE ESTIMATION, MAGNITUDE PRODUCTION, CROSS-MODALITY, MATCHING, LOUDNESS BALANCE

OBJECTIVES: The main objective of this investigation is to further develop, test, and ultimately, standardize a direct psychophysical scaling procedure for the measurement of loudness recruitment in a routine clinical setting. Particularly important, is the potential to distinguish between cochlear and retrocochlear pathology.

RESEARCH PLAN: The participants, all with bilateral hearing losses, will be subdivided into three groups on the basis of their pure-tone audiograms. The groups will consist of those with mild-moderate losses, those with severe losses, and those with profound losses. From 20 to 30 listeners will be included in each subgroup. In addition, from six to eight listeners with unilateral cochlear impairment in each of the three hearing loss groups will participate in the study. Fifty listeners with normal hearing will serve as a control population.

METHODS: First, the subjects will receive a complete otological examination and audiological evaluation. After the initial assessment process, that will also include a visual screening test, loudness in the impaired frequency region will be measured primarily by the direct psychophysical scaling procedures of magnitude estimation, magnitude production, and cross-modality matching. A limited number of alternate binaural loudness balances between a tone in the normal ear and a tone at the same frequency in the opposite, impaired ear will also be performed.

RESULTS TO DATE: We have gathered data on 40 people with normal hearing and 7 people with hearing impairment. Data analysis from 33 people with normal hearing shows that, on the average, the difference between the predicted and measured loudness exponents is +.05. A portion of this work has been reported in the Journal of the Acoustical Society of America 77(1): S64, April, 1985, in the Proceedings of Inter-Noise Vol. 1:929-933, September, 1985 and in Acustica, in press.

	Total Funding	Personnel Services
	$	$
83	-0-	-0-
84	-0-	$ -0-
85	$ 70,454	51,995

TOWARD DEVELOPMENT OF BETTER METHODS OF NERVE REPAIR AND EVALUATION

HENTZ, VINCENT R., M.D. 640 PALO ALTO, CA
PROJECT 2
LAST REPORT, PROGRESS 01/85

ASSOCIATES: Cummins, KL Abraham, G

REGENERATION, NERVE, ELECTROPHYSIOLOGY
The objective of this project is the development of better methods of nerve repair and better methods to evaluate nerve regeneration following repair. The research plan involves the study of sutureless methods of nerve repair and the effects of adjuncts such as drugs to inhibit scar formation, the trophic effects of electropmagnetic fields, and nerve growth factors. Simultaneously, objective evaluation methods to be developed include reliable methods to evaluate and characterize a focal lesion using computer derived estimates of the number of axons crossing a focal lesion and their distribution of added conductio delays.
Methodology: Sutureless repair techniques have been evaluated in groups of primates. Preliminary analysis of the data for both tensionless repairs and repairs performed under tension or with the use of nerve grafts, indicate that sutureless repair methods provide regeneration equal to standard suture techniques in a well-developed rat sciatic-peroneal model. Effects of adjuncts to repair are being evaluated. These studies are on-going regarding objective measurement techniques. The softwear to analyze the distribution of added delays at a repair site have been developed and are being tested. In collaboration with John Wikswo, Ph.D., of Vanderbuilt University, a new method of intraoperative recording utilizing measurements of a magnetic field created by the propagation of an action current along a nerve is being tested in rat and primate nerve models.
Conclusions to Date: We conclude that new mechanical methods of nerve repair alone will not enhance regeneration and functional recovery. Modern mechanical methods must be combined with effective adjuncts such as scar inhibitors, and trophic factors before regeneration will be improved. Secondly new methods to analyze the wave forms of evoked potentials, both intra- and extra-operatively will be useful in objective evaluations of regeneration.

	Personnel Serv
FY'83 - $ 82,879.	$38,726
FY'84 $ 78,543	$51,380
FY'85 - $ 57,653	$34,600

Miller/Galante Porous Tivanium Total Knee System Clinical Trial
HOFMANN, AARON A., M.D. 660 SALT LAKE CITY, UT
PROJECT 2
LAST REPORT, INITIAL 09/84

ASSOCIATES: Dunn, HK Newman, AP

TITANIUM TKA BONY INGROWTH SYSTEM

This is a clinical study of the effectiveness of porous titanium in promoting bony ingrowth for fixation of total knees. We have had prior clinical experience with the surface geometry of this knee, however, in the past it had to be fixed to bone with PMMA cement. We recently have completed a similar study of bony ingrowth into porous cast cobalt chrome alloy and this proved to be an effective means of fixing total knees. This study will determine whether porous ingrowth using a titanium alloy is an effective means of securing the interface between total knees and bone.

Adults seen in the orthopedic clinic who are candidates for traditional total knee replacement because of pain will be offered the Miller/Galante cementless knee. A separate consent form documenting the experimental nature of bone ingrowth with titanium will be obtained. These knees will not be done in minors, mentally disabled, incarcerated patients, prisoners, etc. All data will be kept secured in the Division of Orthopedic Surgery.

The risk is that ingrowth will not occur in the implant and will then have to be cemented in a traditional manner by a second procedure. Potential benefit to the patient is that titanium has much less free ion release into the body because of its high corrosion resistance as compared to the other metals and could have better long term biocompatibility.

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Investigation of Cementation Techniques for Hip Resurfacing Prosthesis
HOFMANN, AARON A., M.D. 660 SALT LAKE CITY, UT
PROJECT 1
LAST REPORT, FINAL 02/85

ASSOCIATES: Daniels, AU

hip, surface replacement, arthroplasty, cementation, loosening

The original objective of this project was to investigate modified cementing techniques for improvement of fixation in surface replacement hip arthroplasty (SRHA). From initial laboratory work, and increasing worldwide clinical reports of early SRHA failures due to loosening, it quickly became clear that improvements in cementation technique alone would not solve the problem of SRHA failure. Accordingly, efforts in this project were refocused on identifying the probable causes of such failures and developing laboratory capabilities for investigating them.

After extensive review of the clinical literature, it was concluded that the probable causes of early SRHA failure were: (a) poor initial mechanical fixation due to inadequate operative technique/instruntation, (b) bone necrosis secondary to disruption of the blood supply, (c) low initial bone strength and (d) bone remodeling due to either stress redistribution related to prosthesis design or aging and disease processes.

To study these causes, two principal capabilities have been developed in our laboratories. The first is bone histomorphometry. Specimens of bone can be stained, sectioned, ground and analyzed with a microscope system interfaced to a microcomputer. The system allows quantification of bone volume and bone resorption/deposition activity. The second is a technique for extended-scale determination of bone macrohardness. This allows mapping of bone mechanical properties and correlation of mechanical properties with structure. Establishment of these capabilities prepared our research team for submission of a successful VA merit review application to study the causes of early SRHA failure in detail.

	$ TOTAL	Personnel Svcs
F/'83	40,341	$36,921
F/'84	$39,259	$30,084
FY'85	$39,426	$26,480

Skeletal Aging & Disease in Failure of Hip Surface Replacement

HOFMANN, AARON A., M.D. 660 SALT LAKE CITY, UT
PROJECT 3
LAST REPORT, INITIAL 02/85

ASSOCIATES: Daniels, AU France, EP

HIP, RESURFACING, PROSTHESIS, AGING, LOOSENING, FAILURE, HISTOMORPHOMETRY, HARDNESS

Project objectives are to determine causes of early loosening in surface replacement hip arthroplasty (SRHA), and relationships between these causes and skeletal aging or disease. Possible causes include: (a) poor initial fixation due to inadequate operative technique and instrumentation, (b) bone necrosis secondary to disruption of the blood supply, (c) inadequate initial bone strength and (d) bone remodeling due to stress redistribution related to prosthesis design or to processes of aging and disease.

Objectives will be achieved by studying the histologic structure of human hip specimens, quality of fixation in mock SRHAs performed on them, and stress distribution in mechanical models of the proximal femur, acetabulum and implant components. Hip specimens will include femoral head/neck material removed from patients receiving conventional total hips and similar specimens from fresh cadavers with normal hips.

Bone structure and metabolic activity will be assessed by histomorphometry techniques including pre-operative tetracycline labeling, preparation of undecalcified bone sections, and computer-assisted optical microscopy for determination of bone volume, and resorption/deposition activity. Bone mechanical properties will be assessed by macrohardness mapping, correlated with conventional measurements of bone strength and stiffness in compression and shear. Initial strength of SRHA component fixation will be tested in torsion. Fixation specimens will also be subjected to several thousand cycles of simulated walking loads and retested for early loosening.

	Total Funding	Personnel Services
83	$40,341	$36,921
84	$39,209	$30,084
85	$39,426	$26,400

Diabetic Neurotrophic Ulceration: Screening and Prevention Utilizing Aesthesiometry
HOLEWSKI, JOHN, D.P.M. 662 SAN FRANCISCO, CA
PROJECT 1
LAST REPORT, INITIAL 09/85

Diabetic Peripheral Newopathy, Newotrophic Ulceration, Anesthesiometry

Development of neurotrophic ulceration in the diabetic patient leads to amputation of limb and disability of these patients. Currentlv most information and effort is directed at treatment of the already formed neurotrophic ulceration. Information is know on prevention, but effective methods for quantitating the overall status of the diabetic foot are lacking. New criteria is needed on the variables which cause ulcer formation. This study will focus on peripheral neuropathy and its relationship to the diabetic's loss of protective sensation leading to ulceration.

It is proposed that Semmes-Weinstein Aesthesiometry measuring cutaneous touch pressure sensation could be an effective, practical method for quantitating the extend of peripheral neuropathy in the lower extremity of diabetic patients. New criteria utilizing aesthesiometry can be established which can assist in the diagnostic process to predict the relative risk of development of neuropathic fool ulceration in the diabetic population.

This project will follow 100 diabetic patients divided into three risk groups of equal size: low, medium and high on the basis of cutaneous touch sensation. These patients will be followed with non-invasive screening tests three times annually, in addition to their regular routine foot care. This proposed project is a survey of a patient population no alterations in patient treatment will be done. The screening tests will include cutaneous sensation testing, a photograph of the plantar surface of the foot to document lesions and foot structure and completion of a history/ physical questionnaire which will be used as a data base.

The database will be analyzed by Clinfo statistical packages on the station-wide PDP11-24 computer, especially noting changes in cutaneous touch sensation and occurrance of ulcerations. Data will be evaluated to determine if cutaneous sensation is an effective parameter for division of risk groups. Each risk group will be evaluated to determine what other variables cause differences within the group. In addition, to determining the efficacy of aesthesiometry in quantitating peripheral neuropathy, this analysis of the database will provide a clearer understanding of the variables of ulcer formation and their relation to peripheral neuropathy.

Clinically, this information can be used to enable one to intervene with appropriate treatment or preventative measures to control or prevent occurrence of diabetic neurotrophic pedal ulceration.

	Total Funding	Personal Services
83	$-0-	$-0-
84	-0-	-0-
85	$6058	$6,058

Measuring the Mobility of Blind Travelers
HOLLYFIELD, REBECCA L., Ph.D. 578 HINES, IL
PROJECT 2
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Courington, SM Trimble, JL Farmer, L

BLIND MOBILITY, BLIND TRAVEL, MOBILITY SKILLS, TRAVEL ACTIVITY, GAIT MEASUREMENT, RASCH ANALYSIS

A valid evaluation of a blind mobility training program requires that the means be available for sufficiently measuring the effect of the program on the blind traveler. In the past, two different approaches have been used in measuring the blind traveler's mobility. One, a measurement of the travel skills of the traveler was made; two, a determination of the amount and type of travel for the traveler was made.

Earlier attempts at both of these types of measurements have been less than optimal and also both types of measures have not been compared to each other. As a consequence, the relationship between travel skills and travel behavior is not known. Recent improvements in those two types of measures have made it feasible to study that relationship now.

One of these improvements is the use of a portable, ultrasonically based dait measuring system that was developed at the Hines VA Rehabilitation Research & Development Center. This system provides measures of the traveler's step length, time and cadence while they are walking. The other improvement involves the use of a more psychometrically valid questionnaire for assessing the travel behavior of the blind person.

The study underway measures the travel skills and behavior of two groups of veterans. One is a group of low vision travelers and the other, blind travelers. The travel skills are measured by the interankle distance measuring system and the travel behavior by the Travel Inventory. These measures are made on four occassions; two are prior to training and two after.

The relationship between these two sets of measures and across the four measurement points will be assessed at the end of data acquisition, which is still underway. It is hypothisized that the level of travel behavior at the fourth measurement will not be fully explicable in terms of the acquired travel skills. This is supposed because there are other factors in addition to travel skill that affect actual travel behavior.

F.Y.'83	F.Y.'84	F.Y.'85
$15,150	$50,344	$17,341

Research dollars provided in support of this project is as follows

F/83 $10,400
F/84 $30,675
F/85 $2483

FOREIGN BODY REACTION IN THE LUNG TO INTRAVENOUSLY INJECTED BIOMATERIALS
HOOD, C. IAN, M.B., Ch.B. 573 GAINESVILLE, FL
PROJECT 1
LAST REPORT, PROGRESS 06/85

INFLAMMATION GRANULOMA BIOMATERIALS FOREIGN BODY

OBJECTIVE OF THE PROJECT: The objective of this project is to define quantitatively and qualitatively the cellular and kinetic events in inflammation as they relate to the properties of biomaterials and to the modulation of host response by antiinflammatory agents.

RESEARCH PLAN AND METHODOLOGY: The plan of this research is to invesigate the inflammatory response to small particles of biomaterials injected intravenously and embolized to the lung or placed surgically into the tissue of mice. The focus of this project is the determination of cellular responses to foreign materials and the understanding of the modulation of these responses to foreign materials and the understanding of the modulation of these responses by the variable characteristics of the material. A standard test system of 45-53 mum divinyl copolymer beads is being used for comparing the inflammatory response, in the lung & in tissue, of various biomaterials such as Bioglasses and the drug-transporting polymer poly d, 12-lactide. The granulomas which form are measured with a digitizer attached to a Radio Shack TRS 80Model microcomputer with whuch the data was statistically analyzed histograms prepared. Cellular changes are observed in thin sections prepared with an LKB Ultratome II ultramicrotome and viewed with a Philips EM 300 electron microscope.

FINDINGS, RESULTS OR CONCLUSION REACHED TO DATE: The results of our study of a model system of inflammation using divinyl benzene copolymer beads was published December, 1984 (J. Biomed. Mater. Res. 18:1031-1042) and a second paper reporting the modulating effects of anti-inflammatory agents on this system has been revised and resubmitted, with a subsequent study underway on the effects of short term modulation by these agents on long term reaction to implanted biomaterials. A study of the inflammatory response of the drug delivery system poly d, 1-lactide has been completed and a paper is in preparation. Studies continue on the reactivity of various Bioglasses and the mechanism of giant cell formation using methylpredisolone acetate to enhance the response.

FY'83	FY'84	FY'85
$54,800	$17,572	-0-

The amount of personal service dollars provided in support of this study is

F/83 $66,892
F/84 $12665

Modulation Transfer Function as a Predictor of Speech Intelligibility

HUMES, LARRY E., Ph.D. 626 NASHVILLE, TN
PROJECT 1
LAST REPORT, FINAL 11/83

Objective: To study the relationship between speech intelligibility for English speech materials and a physical index known as the modulation transfer function (MTF).
Plan: The first objective is to establish the relationship between the MTF and speech intelligibility for English materials (nonsense syllables, monosyllabic words, sentences) assessed under a wide variety of listening conditions. All prior work with this index has made use of Dutch materials. The second goal is to apply the MTF concept to an analysis of speech intelligibility performance in hearing-impaired listeners with and without amplification. Thus far, it has only been applied to speech understanding in normal hearers.
Method: The MTF utilizes a "systems" approach to the assessment of the effectiveness of speech transmission. The standard input to the system is a 100% sinusoidally intensity-modulated noise whose spectrum is identical to the long-term-average spectrum of speech. Modulation frequencies are selected to span the range observed in running speech (0.25 to 25Hz). The quantity of interest in the output of the system is the depth of modulation as a function of modulation frequency. A series of five experiments (one using electroacoustic methods and the remainder employing psychophysical techniques) have been designed.
Clinical Relationship: Assist in defining the deficit in speech understanding ability experienced by hearing-impaired persons.

Funding Allocation	Personal Services
FY'83 - $ 40,976	$ 36,976
FY'84 - $ - 0 -	—
FY'85 - $ - 0 -	—

Assistive Powered Devices for High Spinal Cord Injured Person
HUSSEY, ROBERT W., M.D. 652 RICHMOND, VA
PROJECT 1
LAST REPORT, INITIAL 12/84

ASSOCIATES: Schmeisser, G

ROBOTIC ARM, SPINAL CORD INJURY, QUADRIPLEGIA, ASSISTIVE POWERED DEVICES

OBJECTIVES: The purpose of this project is to evaluate by clinical trial the utility of the JHU/APL Robotic Arm/Worktable System in providing assistance to high level quadriplegics.

RESEARCH PLAN: Utilizing patient volunteers, evaluation of the complete Robotic Arm/Worktable System which includes an adapted wheelchair with specialized chin control, a powered Robotic Arm and a two-station worktable, including telephone, computer, printer, book rack, feeding station and disk drive manipulating system in determining the practicality of this device, modifications of individual components and overall layout of worktable. A series of defined tasks were defined and each patient was given a training period for each task and then standard evaluation was carried out in patient's performance of those tasks. Detailed notes of each patient's participation, time to carry out various activities and patient's subjective comments were kept.

METHODS: Following a defined protocol, volunteers were assessed in the operation of the Robotic Arm.

RESULTS TO DATE: A total of nine patients have been evaluated since the beginning of this project. They have ranged in age from 21 to 49 years, and time of injury from five months to ten years. All were high level quadriplegics at the C-3, C-4 or C-5 level, including patients who were respirator dependent. As a result of this evaluation changes have been made in the wheelchair control system, as this was identified as a particularly weak feature of the system. A new wheelchair controller is anticipated to be received soon. It was identified that the original telephone setup interferred with operation of other components of worktable and this has been modified. The combination of a typewriter and a computer and printer were unnecessary, in that the printer controlled by a computer with word processing software was a much more effective and efficient method and allowed removal of one large piece of apparatus from worktable. The original Morse Code paddle input system was difficult to utilize efficiently and effectively by many patients. Additional forms of input devices have been attempted, including voice input, puff and suck Morse Code input and most recently a bite control input device. It was found that the combination of voice input plus Morse Code input resulted in a most efficient system for the patients. Self-feeding was the most variable in its desirability to the patients. Some patients very much preferred this feature, others were not interested in it at all. This compares to the computer use portion of the worktable in which all patients were highly motivated and interested in utilizing this aspect of the worktable.

FUTURE DIRECTIONS: The most important future direction anticipated for this project is that it will lead to the development and evaluation of a

	Total Funding	Personal Services
83	$ 16,000	$78,000
84	$ 18,234	$16,234
85	-0-	-0-

commercially available prototype. It is felt that the evaluations to date have defined various deficiencies and areas for improvement in the system and should allow an effective development of a commercially available prototype. This project has demonstrated the utility, versatility and desirability of this device for selected patients. The experience will allow the development of appropriate training manuels so that this device can be utilized extensively in the field.

Wheelchair Usage Monitor
HUSSEY, ROBERT W., M.D. 652 RICHMOND, VA
PROJECT 2
LAST REPORT, INITIAL 12/84

ASSOCIATES: McLaurin, CH

WHEELCHAIR MONITOR, WHEELCHAIR STANDARDS

OBJECTIVES: The objective is to develop a practical and reliable method to accurately determine usage of wheelchairs in normal activity and the stresses applied to such wheelchairs. The objective is to develop a simple, reliable and inexpensive device that can be used in validation of wheelchair standards.

RESEARCH PLAN: Utilizing microcircuitry and microprocessors to develop a monitor which could be simply attached to a wheelchair and provide information as to time and distance used and various acceleration forces applied to the wheelchair.

RESULTS TO DATE: Though this project has been approved for Fiscal Year 1985, the necessary contract has not been at this point finalized administratively and, therefore, no work has been carried out on this project.

	Total Funding	Personnel Service
83	$30,000	$19,832
84	$28,346	$18,456
85	$28,803	$27,900

Bioengineering Aspects of Fracture Healing (new title)
Sonic and Radioisotopic Assessment of Fracture Healing in Dogs (old title)
JACOBS, RAE R., M.D. 589 KANSAS CITY, MO
PROJECT 3
LAST REPORT, FINAL 10/85

ASSOCIATES: Doemland, HH Reese, C

FRACTURE HEALING, FRACTURE STABILITY

OBJECTIVE: To improve the rehabilitation of the trauma patient by applying bioengineering to diagnosis and treatment of fractures.

PLAN: To measure reduction, stability, and strength of pelvic and long bone injuries stabilized by various techniques. To quantitatively measure fracture healing non-invasively.

METHODS AND RESULTS: The stiffness and strength of compression hip screw fixation of cadaveric intertrochanteric fractures were found to greatly excede that of multiple pin or single nail intramedullary fixation. A prototype external fixator for pelvic fractures is nearly 3 times stiffer than existing systems in cadaver testing. Screw and washer fixation for attachment of torn medial collateral ligaments of the knees is far superior in strength and stiffness after eight weeks of healing in a canine model than the traditional spiked staple, but was significantly below that of the intact ligament. A microprocessor based resonant frequency bone analyzer has been developed and tested. The intraevaluator variability (95%) is +/- 5% and interevaluator variability +/- 10% whereas the decrease after fractures is 50%. The primary resonant frequent peak is related to the second mode of bending and the area of bone at the "fracture site" in a cadaver tibia experiment. The device correctly predicted the union or non-union of canine fractures in 90% of cases.

CLINICAL RELATIONSHIP: Intertrochanteric fractures are more stable when internally fixed with conversion hip screw than with intramedullary devices. Pelvic fractures can be adequately stabilized with a new external fixator. Medial collaterol ligament tears are better reattached with screw and washers than spiked staples. The resonant frequency bone analyzer is in multicenter clinical evaluation and agreements in progress for commercial manufacture. Seven papers have been published or submitted.

This project is being terminated and re-initiated as Project 004.

F.Y.'83 $ 110,270
F.Y.'84 $ 58,763
F.Y.'85 $ -0-

Research Service dollars provided in support of this study are as follows:"
F.Y.'83 - $ 37,794
F.Y.'84 - $ 85,763

Evaluation of Female External Urine Collection Device
JOHNSON, DAVID E., PH.D. 512 BALTIMORE, MD
PROJECT 2
LAST REPORT, INITIAL 03/85

Urinary Incontinence, Females, Bacteriuria
PROJECT OBJECTIVE: To evaluate and refine the design of a external device used to collect urine from incontinent women.
PLAN: A prototype device will be evaluated in normal, healthy volunteers. A redesigned device will be evaluated in patients.
METHOD: Device evaluation will include ease of application to the patient/volunteer, whether the device is comfortable, whether it leaks, whether it is reliable for collection of urine cultures while the device is in place and the length of time the device can be worn.

	Total Funding	[illegible]
FY83	-0-	-0-
84	$4,000	-0-
85	$84317	$62840

Fracture Fixation and Healing - Project 1: Non Invasive Assessment of Fracture Healing
JONES, RICHARD E., M.D. (184) 549 DALLAS, TX
PROJECT 11
LAST REPORT, PROGRESS 06/85

ASSOCIATES: Bucholz, RW Mooney, V Strauss, MG

OBJECTIVE: To devise a method to quantify the strength of a healing fracture.

RESEARCH PLAN: 30 patients with closed or grade I open tibial fractures will have their fractured tibia and normal tibiae tested for their natural frequency during the healing period, (typically 20 weeks post injury.) A dog study will be performed consisting of 20 dogs. One tibia in each dog will be fractured. The natural frequency of both tibiae will be tested at weekly intervals. Sacrifice, harvest, and strength testing of the tibiae will be performed at weekly intervals.

METHODOLOGY: The natural frequency of the tibia can be determined by tapping the medial malleolus with an instrumented hammer and measuring the resulting vibrations with an accelerometer pressed against the skin at the tibial tuberosity. Both signals undergo FFT and the transfer function yields the natural frequency.

RESULTS: With a standardized protocol well developed, reproducibility of the natural frequency of the normal tibia are (plus or minus)5% in the relaxed patient. Strong correlation between location and natural frequency has been found, as well as between the normalized natural frequency squared and the time cost injury. (The normalized natural frequency is the fractured tibia natural frequency divided by the normal tibia natural frequency.) The dog study should provide the now missing information of how the strength of the healing tibia relates to it's natural frequency. To date, 25 patients have been entered into the study.

F/'83 F/'84 FY'85
$89,857 $83,660 $98,300

Overall Services funding for all three years is as follows:
F/'83 $6164
F/'84 $32126
F/'85 29,249

PROGRAM: Fracture Fixation and Healing----Project 2. Variable Stiffness External Fixation
JONES, RICHARD E., M.D. 549 DALLAS, TX
PROJECT 12
LAST REPORT, PROGRESS 04/84

ASSOCIATES: Tencer, AF Bucholz, RW Johnson, KD
Mooney, V

Objective: To develop a method to permit progressive load sharing with a healing fracture. To devise a method for determining the structural properties of a healing fracture to be compared with results of Project 1.

Research Plan: a) Compare methods of producing a variable rigidity fixation frame, b) devise a system for measuring frame deflection under load, c) perform measurements clinically.

Methodology: A triangulated 8 pin, 2 sidebar frame was tested in various stages of disassembly to devise a protocol for progressive loading. As well a frame with variable modulus components was investigated using structural analysis theory and experimental verification. An experimental frame with a biaxial transducer to detect bending in the sidebar was obtained from the Oxford Orthopedic Engineering Center, UK, and is being used to obtain clinical measurements of the stiffness of healing fractures.

Results: Several methods of progressive load sharing in fractures using fracture frames appear feasible. A triangulated frame based on AO components can be progressively dismantled by removing pins and sidebars sequentially providing a reduction in stiffness in bending, axial and torsional loading. Using a unilateral frame of specific rigidity permits progressive load transfer to the fracture callus as it heals without the necessity of altering the frame. The use of a small spring in the frame to control axial motion is unnecessary. Presently clinical measurements of fracture stiffness are being performed.

Efficacy of Remote TEL-Communicology Delivery of Aphasia Treatment
KEARNS, KEVIN P., Ph.D. 629 NEW ORLEANS, LA
PROJECT 1
LAST REPORT, PROGRESS 08/85

ASSOCIATES: Vaughn, G Amster, W Rudd, A

APHASIA, COMPUTERS, TEL-COMMUNICOLOGY

The purpose of this study is to compare the efficacy of Face-to-Face clinic treatment with TEL-Communicology treatment of aphasic patients. Face-to-Face delivery of treatment consists of clinician-delivered treatment within the clinic setting. TEL-Communicology treatment involves clinician-assisted and computer-assisted delivery of services to aphasic patients via telephone in their places of residence. The treatment project includes the Study Center at Birmingham Veterans Administration Medical Center and three Field Centers at Little Rock, Miami, and New Orleans VAMC. Patients meetings selection criteria will be randomly assigned to Group I (Face-to-Face treatment) or Group II (TEL-Communicology treatment). Each subject will receive twenty-four (24) weeks of treatment consisting of five (5) hours each week distributed over at least three (3) different days. A battery of language measures will be administered to each subject at pre-treatment, 8, 16, and 24 weeks to evaluate the relative effectiveness of Face-to-Face and TEL-Communicology treatment.

To date, twenty (20) veterans from the New Orleans VAMC have participated in this study. Eleven (11) subjects were randomly assigned to the Face-to-Face treatment group and nine (9) subjects entered the TEL-C treatment group. All subjects in both groups completed at least eight (8) weeks of treatment. Eight subjects completed the entire twenty-four (24) week treatment protocol and four (4) New Orleans VAMC subjects are currently participating in the study.

	Total Funding	Personnel Service
83	$62,073	$60,911
84	$75,049	60,327
85	$54,022	$54,022

Incorporated into the Vaughn study

Development of Linear Synchronous Drive for Wheelchair Use

KELLY, GARY W. 508 DECATUR, GA
PROJECT 17
LAST REPORT, INITIAL 05/85

ASSOCIATES: Ross, D

Rahabilitation, Wheelchair, Power-train, Motor, Linear, Synchronous
OBJECTIVE: To develop a wheelchair power drive system that is highly efficient, light-weight, and inexpensive. Target populations are spinal cord injury, arthritis, stoke, multiple sclerosis, muscular dystrophy, cerebral palsy and brain trauma.
DEVELOPMENT PLAN: A mathematical model of the physical prototype will be constructed and will be followed by the mechanical design of the linear synchronous field coils and mounting hardware. A three-phase controller will be designed and the first prototype will be assembled for bench testing. Tests will be performed under various loads and running conditions which best stimulate actual wheelchair indoor and outdoor usage.
METHODS: A Hewlett Packard Series 200 computer will be used to develop the mathematical model and to generate the mechanical drawings. The three-phase power stage will be microprocessor controlled (6809) with MOSFET power processing. A (Hewlett Packard 64000) development system will be used for Assembly language programming.

	Total Funding	Research Support
83	-0-	-0-
84	-0-	-0-
85	$71,490	$25,100

Active Physical Therapy: Application of FES to Rehabilitation Medicine
KIMURA, KAZUO, M.D., Ph.D. 552 DAYTON, OH
PROJECT 2
LAST REPORT, FINAL 07/85

ASSOCIATES: Phillips, CA Gardier, RW Stacy, RW

This project was terminated for other than scientific reasons.

During the time this project was active, experiments referred to in the planning as "exploratory experiments" were completed, and are reported herein. These experiments involved studies of effects of eight weeks of exercise, at three exercise sessions per week with 15 minutes of bicycling per session on a number of physiological parameters. The study group included ten subjects (seven quadriplegics and three paraplegics). Observations included (A) measures of muscle size and endurance, (B) assessments of pulmonary function, and (C) assessments of cardiovascular functions.

Endurance, measured as the mean time of cycling before fatigue, increased from 4.75 minutes to 14.24 minutes as a result of the exercise program. These results were statistically highly significant (P less than .010). Leg girth increased approximately 4% in the left and right thighs, measured 10 cm. and 20 cm. above the upper patellar margin. These changes were also statistically significant (P less than .05). Girth of the lower leg (calf) did not increase.

Pulmonary parameters that were significantly changed included those associated with the ability to move air rapidly. Forced Vital Capacity (FVC), Forced Inspiratory Capacity (FIC), Forced Vital Capacity at one second (FEV1), Minute Ventrilation (MV) and Respiratory Rate (RR) were all significantly increased (P less than .05).

Heart rate, cardiac output, and peripheral resistance, measured by standard hemodynamic technics, were changed significantly (P less than .05) by the exercise. The P-R interval of the ECG was decreased, reflecting the heart rate increase. Cardiac output and cardiac index, measured by echocardiography, were significantly changed. Of cardiovascular reflexes studied, only the tilt test was significantly altered.

This study identified a number of parameters that could and should be studied in detail in more extended experimentation.

	Total Funding	Personnel Service
F/83	$72,000	-0-
F/84	$570,563	$76,066
F/85	$392,972	$4,898

Effect of Auditory Cues in Computer-Assisted Instruction in Lipreading
KOPRA, LENNART L., Ph.D. 674 TEMPLE, TX
PROJECT 1
LAST REPORT, FINAL 10/84

Aural rehabilitation, computer-assisted instruction, lipreading

The objectives of this project have been (1) to assemble instrumentation for the presentation of videotaped lipreading stimulus materials under computer control for interactive computer-assisted instruction (CAI) in lipreading, (2) to provide new information on the effectiveness of CAI used as supplementary drill and practice in a program of lipreading instruction for post-lingually hearing-impaired adults, and (3) to develop lipreading instructional materials for hearing-impaired adults.

The following work has been accomplished: (1) for lipreading drill and practice, the utility of a videocassette interactive system under computer control has been examined and evaluated, (2) a laser videodisc interactive system has been assembled and has been demonstrated to operate efficiently for CAI in lipreading, (3) 1,357 consonant-vowel-consonant words (CVCs) have been generated for use as minimal viseme contrasts in lipreading instruction, (4) 12 lists of 25 sentences each which are sequentially and progressively more difficult as lipreading stimuli have been standardized for drill and practice exercises with CAI in lipreading, (5) the 12 lists of sentences (300 sentences) have been pressed on videodisc and have been programmed for use with the laser videodisc interactive system which provides auditory redundancy (sound clues) and, in another condition, linguistic redundancy (word clues) during CAI in lipreading, and (6) 12 one-hour lipreading lessons have been developed for use in aural rehabilitation program. The effectiveness of these lipreading materials and procedures for development of lipreading skill will be examined with postlingually hearing-impaired adults.

	Total Funding	Personnel Serv
F.Y83	$83,370	N/A
F.Y84	$3,500	N/A
F.Y85	$101,891	$21,000

Development of Materials for Computer-Assisted Instruction in Lipreading
KOPRA, LENNART L., Ph.D. 674 TEMPLE, TX
PROJECT 2
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Dunlop, RJ

AURAL REHABILITATION, COMPUTER-ASSISTED INSTRUCTION, LIPREADING

The objective of this project is to develop stimulus materials and procedures for applying a laser videodisc interactive system to computer-assisted instruction (CAI) in lipreading for hearing-impaired adults. A computer system has been designed and software has been written for an auditory-visual laser videodisc interactive system (ALVIS) which is used for drill and practice in CAI. The system includes: a laser videodisc player, microcomputer, keyboard, video monitor, two microfloppy disk drives, dot-matrix printer, external amplifier and attenuator, programmable attenuator with associated accessories, and earphones. Twelve lists of 25 sentences each have been standardized and arranged in order of difficulty from easiest to most difficult as lipreading stimuli. These five- to eight-word sentences, presented in order of difficulty, were recorded on one-inch videotape and then pressed on videodisc. Presentation of a talker saying each of the 300 sentences is under software control by ALVIS in each of two conditions. Each sentence is presented a maximum of five times; the first presentation is without any clues. In the first condition, word clues are presented on the video monitor; in the second condition, auditory clues accompany the visual stimulus. ALVIS is being used experimentally in a program of aural rehabilitation which includes lipreading instruction for postlingually hearing-impaired adults. The goal of this program is to examine the effects of supplementary drill and practice with ALVIS on the development of lipreading skill. Future activities will include the production of additional stimulus materials on videodisc and the programming of these materials for diagnostics and aural rehabilitation therapy. The final plan is to disseminate lipreading materials and procedures from this project to aural rehabilitation programs in the Veterans Administration and elsewhere.

Development and Evaluation of Wheelchair Feedback Controllers
LA, WILLIAM H.T., Ph.D. 640 PALO ALTO, CA
PROJECT 1
LAST REPORT, PROGRESS 08/83

ASSOCIATES: Perkash, I Leifer, LJ Smith, RE

WHEELCHAIR, CONTROLLER, MICROPROCESSOR, POWER SYSTEM

This project has as its goal the development of a digital wheelchair feedback controller intended to ease the control burden of the powered wheelchair user. The proposed path of development was to first mathematically model the physical characteristics of various types of wheelchairs for subsequent computer simulation of different types of control algorithms. The Palo Alto VA Medical Center has acquired a Singer-Link Digital Image Generation System (DIGS) through a donation and agreement with Singer-Link and Stanford University. This vehicle simulator has been integrated into the plans for the project: the DIGS will be used to perform the controls simulation and user preference portions of this investigation, in tandem with investigations of real wheelchair hardware. The simulation portion of this project is presently awaiting the completion of building modifications at the Western Blind Rehabilitation Center. A microcomputer-based wheelchair controller development system has been completed, and a power system for wheelchairs using power MOSFETs has been developed. These are silent, smaller, and more efficient and reliable than ordinary wheelchair power systems. A test protocol for the evaluation of the various control algorithms has been outlined and two simulator test sites are in preparation: a simulacrum of Stanford shopping center, and an obstacle course.

Publications: 1. Digital Controls for an Omnidirectional Wheelchair, Smith, R.E., Proceedings of the 1983 IEEE American Controls Conference. 2. Development of a Microprocessor-based Wheelchair Feedback Controller, Smith, R.E. and La, W.H.T., Proceedings of 6th Annual Conference on Rehabilitation Engineering, 1983. 3. User-Computer Interaction in an Omnidirectional Vehicle, Smith, R.E. and La, W.H.T., ACM/IEEE Hawaii Conference on System Sciences.

	Personnel Svcs
F/'83 $- 79,600	$24,800
F/'84 $- 95,014	$27,360
F/'85 $ 21,100	$13,632

A Study of the Effectiveness of a Blind Rehabilitation Program (new title)
LAMBERT, ROSS W. JR, M.D. 578 HINES, IL
PROJECT 3
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Becker, SW Wright, BD

EVALUATION RESEARCH; QUALITY OF LIFE MEASURES; VALIDATION OF SELF REPORT SCALES; NEEDS ASSESSMENT; BLIND REHABILITATION

OBJECTIVE: The study is designed to measure the effectiveness of a blind rehabilitation program in improving the quality of life of blind patients. Quality of life is operationally defined as comprising attitudes toward self and blindness; psychological state; and independence in daily activities and travel.

METHOD: The rehabilitation program is evaluated in terms of the changes it produces in life state. Participants are measured on mood, attitudes, living skills and travel both before and after rehabilitation training. The instruments have been specially designed to minimize response bias. Data are being examined with standard techniques of multiple and multivariate regression, time series analysis, and other techniques.

FINDINGS: 290 patients have been enrolled in the study and completed the first interview; 185 patients have completed the second interview; and 165 patients have completed the third. Patient enrollment has stopped.

All measuring instruments have been constructed, validated and tested for ability to measure change scores with great sensitivity. They have been reported in the literature and at numerous meetings. An additional measure of veterans' needs has been reported.

The measures provide a sensitive, multidimensional measure of patients progress during and after rehabilitation. They focus on the goals of the rehabilitation program and quickly highlight patients' diminution in skills (forgetting) over time. Taken singly, the measures are a patient measure; taken as a group, they constitute a measure of program effectiveness. This prospective longitudinal measure of effectiveness of therapeutic intervention is being used as the model for future research designs. All measures have met external validity criteria through direct observation, spousal confirmation, or reports of blind rehabilitation professionals.

	Total Funding	Personal Services
83-	$157,300	$95,800
84-	$176,944	$154,775
85-	$81,216	$61,478

Variables Affecting Hearing Aid Performance
LARSON, VERNON D., Ph.D. 509 AUGUSTA, GA
PROJECT 4
LAST REPORT, INITIAL 01/85

ASSOCIATES: Cooper, WA DeChiccis, AR Egolf, DP

EAR CANAL PROBE MICROPHONE, HEARING AID, EAR CANAL VOLUME, EARDRUM IMPEDANCE, FUNCTIONAL GAIN MEASURES

OBJECTIVE: The overall objective of this project is to study aural-acoustic load impedance relationships which underly contemporary hearing aid fitting procedures.

RESEARCH PLAN: For normal and pathologic subjects, ear canal volume data and eardrum impedance data will be studied. Further, the effects of dc pressure differences across the tympanic membrane, aural pathology, and the acoustic stapedial reflex on probe microphone observations of sound spectra and on the transfer of energy through the middle ear will be assessed.

METHODOLOGY: Transducers having high and low acoustic impedance will deliver acoustic stimuli to different acoustic loads. The effect that these relationships have will be studied by probe tube microphone, auditory threshold studies, phase distortion studies and word recognition studies.

	Total Funding	Personnel Svce
83	-0-	-0-
84	-0-	-0-
85	$59,347	$21,566

Acoustic Feedback Suppression in Hearing Aids
LARSON, VERNON D., Ph.D. 509 AUGUSTA, GA
PROJECT 3
LAST REPORT, PROGRESS 01/85

HEARING AIDS ACOUSTIC FEEFBACK EARMOLDS

OBJECTIVE: There are four objectives in this program: 1) To what extent do two earmold designs eliminate stable and unstable acoustic feedback. 2) To develop and amalgamate mathematical models of sound delivery to the listener and feedback paths from the listener and his environment. 3) To evaluate existing circuits used to suppress acoustic feedback and to evaluate three new concepts to suppress acoustic feedback. 4) To develop and evaluate wearable prototypes to suppress acoustic feedback in hearing aids.

PLAN: Electroacoustic study of hearing aid-earmold systems will be accomplished by the principal investigator. Mathematical models and computer programs, evaluation and development of prototypes will be accomplished under contract with the University of Wyoming.

METHOD: Evaluation of earmold elimination of feedback will be performed through realtime spectral analyses. These analyses will be incorporated into computer models of the feedback process, developed by the University of Wyoming. Existing and proposed suppression schemes will be evaluated using the computer method, supported by empirical laboratory data. Prototypes will be designed in the Hybrid Microcircuits Laboratory at the University of Wyoming.

RESULTS TO DATE: A series of laboratory measures of the open-loop transfer function of BTE hearing aids have been made to determine frequencies where corrective action must be taken. Prototype earmolds have been made and subject selection has begun. A microprocessor circuit has been designed and built. THis design is based on a scheme whereby the circuit automatically seraches for frequencies at which the open-loop transfer function is a multiple of 360 degrees. It then automatically locates notch filters at those frequencies. A computer model of the hearing aid in-situ is nearly completed. Ten patients are currently undergoing trial (for ninety days with two-week follow-up sessions) of earmold types. Preliminary results suggest that while the earmolds prevent audible feedback, there are problems associated with patient comfort. Work toward miniaturizing the microprocessor circuit (which provides up to 14 dB of additional stable gain) is under way.

FY'83	FY'84	FY'85
-0-	93,083	$118,354

In FY'84, $12,800 was provided for salaries of project employees. For FY'85, the cost was $25,689.

A Study of the Effectiveness of a Blind Rehabilitation Program (new title)
LAMBERT, ROSS W. JR, M.D. 578 HINES, IL
PROJECT 3
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Becker, SW Wright, BD

EVALUATION RESEARCH; QUALITY OF LIFE MEASURES; VALIDATION OF SELF REPORT SCALES; NEEDS ASSESSMENT; BLIND REHABILITATION

OBJECTIVE: The study is designed to measure tne effectiveness of a blind rehabilitation program in improving the quality of life of blind patients. Quality of life is operationally defined as comprising attitudes toward self and blindness; psychological state; and independence in daily activities and travel.

METHOD: The rehabilitation program is evaluated in terms of the changes it produces in life state. Participants are measured on mood, attitudes, living skills and travel both before and after rehabilitation training. The instruments have been specially designed to minimize response bias. Data are being examined with standard techniques of multiple and multivariate regression, time series analysis, and other techniques.

FINDINGS: 290 patients have been enrolled in the study and completed the first interview; 185 patients have completed the second interview; and 165 patients have completed the third. Patient enrollment has stopped.

All measuring instruments have been constructed, validated and tested for ability to measure change scores with great sensitivity. They have been reported in the literature and at numerous meetings. An additional measure of veterans' needs has been reported.

The measures provide a sensitive, multidimensional measure of patients progress during and after rehabilitation. They focus on the goals of the rehabilitation program and quickly highlight patients' diminution in skills (forgetting) over time. Taken singly, the measures are a patient measure; taken as a group, they constitute a measure of program effectiveness. This prospective longitudinal measure of effectiveness of therapeutic intervention is being used as the model for future research designs. All measures have met external validity criteria through direct observation, spousal confirmation, or reports of blind rehabilitation professionals.

FY'83	FY'84	FY'85
$157300	$176,949	$81,216

Research Service dollars provided in support of this study is as follows:

F/83 $95,800
F/84 $154,995
F/85 $61,408

Seat Cushions for the Paralyzed
LEE, BOK Y., M.D. 533 CASTLE POINT, NY
PROJECT 36
LAST REPORT, PROGRESS 03/85

ASSOCIATES: Bennett, L

Pressure Sores, Shear, Plethysmograph, Seats
Objectives: (1) Clarify pressure sore causation (2) define the role of shear, if any, in pressure sore etiology (3) examine the cutaneous blood flow of seated paraplegic subjects to determine occlusive risk factors in the buttocks regions.
Plan: Monitor blood flow in the region of the ischial tuberosities for seated normal and paraplegic subjects while simultaneously registering sitting loads. Correlate loads with occlusive tendencies and gross states of health.
Methods: Use an instrumented wheelchair seat to measure sitting pressures, shear and cutaneous blood flow (optical plethysmographic devices). Establish blood flow level (AC) by a combination of waveform analysis techniques (harmonic analysis) and magnitude considerations.
Results to Date: Earlier results indicate shear in sitting paraplegics to be a significant factor in cessation of buttocks cutaneous blood flow. Current efforts are concerned with differentiating between the possibilities of larger shear loading, evidenced by paraplegics, as compared to increased shear load sensitivity, in producing occlusion. Pulsatile waveform analysis is being applied to plethysmographic output of sitting subjects to separate these effects. To date some 12 subjects have been studied with the procedure.
Portions of the work have been reported in the Archives of Physical Medicine and Rehabilitation, 60: 390-314, 1979; Ibid 62: 392-298, 1981; and Ibid 65: 186-190, and chapter in book: Chronic Ulcers of the Skin. McGraw Hill Book Company, New York, New York 1984.

F/'83	FY'84	FY'85
$38,060	$63,598	$57,079

The amount of [illegible] dollars provided in support of this project is as follows:

F/'83	$Unavailable
F/'84	$41,400
F/'85	$50,879

A Program for Evaluating the Dysvascular Patient (Project No. 1) (title ch.)
LEE, BOK Y., M.D. (86) 533 CASTLE POINT, NY
PROJECT 45
LAST REPORT, PROGRESS 06/85

ASSOCIATES: Thoden, WR Ostrander, LE

ARTERIOSCLEROTIC OCCLUSIVE DISEASE, LUMBAR SYMPATHECTOMY
Objective: Delineation of place of lumbar sympathectomy in management of atherosclerotic occlusive disease.
Research Plan: To utilize the technique of polarographic monitoring to local hydrogen gas desaturation in the experimental and clinical setting to determine the effect of lumbar sympathectomy on blood flow in subcutaneous and sketetal musculature.
Methodology: Currently the development and use of the H2 clearance technique to assess the hemodynamic effects of lumbar sympathectomy are still being applied in the research lab using the canine model. Application to a group of primates is anticipated. All new clinical cases with and without lumbr sympathectomy are being followed using nonivasive vascular procedures. Subsequently when available the H2 clearance technique will add further dimension.
Results to Date: Preliminary data analysis of lumbar sympathectomy for the gangrene-long term follow-up: retrospective review of 45 patients (50 limbs) with toe gangrene not amenable to direct arterial surgery, and managed by lumbar sympathectomy alone. follow-up data regrding toe salvage, limb salvage & limb loss were compiled. At 5 and 8 year follow-up comulative limbar salvage was 71% and cumulative toe salvage was 51%. The presence of diabetes did not significantly influence limb or toe salvage. Mortality during immediate postoperative period was 2%. In the majority of patients with digital gangrene who are not amenable to arterial surgery, lumbar sympathectomy is of benefit for salvaging the limb and toes.

F/'83	F/'84	F/'85
$44,399	$61,536	$126,047

The amount of [illegible] provided [illegible] support of this [illegible] as follows:
F/'83 $44,399
F/'84 44,416
F/'85 $39,072

A Program for Evaluating the Dysvascular Patient (Project #2) (title change)
LEE, BOK Y., M.D. 533 CASTLE POINT, NY
PROJECT 46
LAST REPORT, PROGRESS 06/85

ASSOCIATES: Thoden, WR Ostrander, LE

MYOCUTANEOUS PERFUSION, SYMPATHECTOMY, HYDROGEN CLEARANCE TECHNIQUE
Objective: To analyze myocutaneous perfusion and obtain hemodynamic data applicable to vascular problems associated with vascular disease: to provide instrumentation that can be used clinically to evaluate the potential amputee with respect to level of amputation consistent with wound healing and to evaluate the patient who requires an arterial bypass.
Research Plan: Development of an instrumentation package involving sensor design and modification for routine clinical use of hydrogen clearance technique and photoplethysmography using controlled animal experimentation followed by clinical verification.
Method: Animal experiments (canine and primate) comparing myocutaneous perfusion measurements with H2 clearance technique and pressure photoplethysmography to measurements made with the electromagnetic flowmeter.
Results: The technqiue of H2 clearance has been used to monitor blood flow in the gastrocnemius muscle following sympathectomy in animal models. The contralateral non-sympathectomized limb was used as control. Average blood flow for the sympathectomized limb was from 33% to 83% greater than contralateral non-sympathectomized limb and the difference was also statistically significant at $p>0.005$.
Clinical Significance: This study has particular relevance for the ever increasing number of veterans with ASOD. Appropriate use of system could provide early information as to the status of limb viability. The increase in muscle blood flow following lumbar sympathectomy, if of prolonged duration, may be a valuable adjunct to direct reconstructive arterial surgery in the management of symptomatic arteriosclerotic occlusive disease.

Geriatric Prosthetics: Design & Development of an Improved Above-Knee Socket
LEHNEIS, HANS R., Ph.D. 630 NEW YORK, NY
PROJECT 1
LAST REPORT, INITIAL 05/84

ASSOCIATES: Rubin, G

The overall objective of the project is to develop an improved above-knee (AK) prostheses specifically designed for geriatric amputees.
Specific objectives are improved prosthetic socket comfort & performance. It is believed that the stump socket interface is by far the most important component in an above-knee prosthesis. A properly designed socket configuration based on fundamental studies of anatomical and physiological factors in the geriatric amputee population as well as biochemical factors in the swing and stance phase will result in:

a. Improved comfort - thus increased patient acceptance and wear of the prosthesis
b. Improved safety in the stance phase through better and selective pressure distribution to prevent knee buckling
c. Improved kinematic control in the swing phase - again through appropriate distribution in the stump socket interface. Thus, patient performance is improved secondary to improved socket fit and comfort.

To achieve these objectives we plan to:

1. Examine and compare
   a. External elements of residual limbs such as tissue compressibility, muscle tone, circulation, sensation, and circumference.
   b. Internal anatomical and physical characteristics of residual limbs by crosssection analysis related to configuration of muscle and soft tissue, in geriatric vs. young amputees, geriatrics vs. young non-amputees, male vs. female subjects.
2. Develop crossectional socket patterns for geriatric amputees, based primarily on tissue compressibility and other parameters from above studies.
3. Experimentally fit geriatric amputees with the new socket configurations.
4. Compare and evaluate fit and performance of the new socket with a conventional quadrilateral socket fitted to the same patients.

	Total Funding	Research Service
83	-0-	-0-
84	-0-	-0-
85	$98,508	-0-

DEVELOPMENT AND EVALUATION OF A ROBOTIC AID FOR THE SEVERELY DISABLED

LEIFER, LARRY J., Ph.D. 640 PALO ALTO, CA
PROJECT 4
LAST REPORT, PROGRESS 08/84

ASSOCIATES: Perkash, I Roth, B

ROBOTICS, REHABILITATION, INDEPENDENT-LIVING, QUADRIPLEGIA, ELDERLY, SPEECH RECOGNITION, SPEECH SYNTHESIS

This project seeks to test the hypothesis that programmable industrial manipulators (Robots) can be adapted to serve the needs of veterans with severe physical limitations (eg. quadriplegia, advanced age).

A two phase research plan calls for the development of a clinical system using "off-the-shelf" technolgoy and a laboratory system with which to advance the state-of-the-art in medical robotics. Clinical and technical performance assessment protocols are specified. The former formulated to access user acceptance and satisfaction. Laboratory accessments have included stability studies, task-time-to-completion studies and voice recognition and intelligibility studies.

The key subsystem in these studies has been the Unimation Inc. PUMA-250 electromechanical manipulator and controller. In going beyond commercially available instumentation we have assembled a Robotic Aid programming facility based on the Digital Equipment Company LSI-11/23 micro-computer using the Pascal programming language, optical proximity sensing and force measurement.

Approximately 90 persons have been trained to use the Robotic Aid. Of this number, 24 were severely impaired persons with spinal cord injury or neurologocak disease. Subjects ranged in age from 5-83 years. The Robotic Aid is are readily accepted than anticipated; while important, safety is not perceived to be a problem; and there appears to be no age related bias against the use of an robotic servant. Robotic Aids are seen to be the key to independent living for a sizable group fo persons who now require institutionalization. As reported, we believe that the feanibility of Robotic Aids has been demonstrated and that the next objective is now to establish the utility of voice controlled Robotic Aids.

	Personal Svcs
F/'83 - $ 239,810	$118,000
F/'84 - $ 200,291	$ 91,309
F/'85 $ - 352,600	$182,600

Development and Evaluation of an Advanced Manipulation Aid
LEIFER, LARRY J., Ph.D. 640 PALO ALTO, CA
PROJECT 6
LAST REPORT, INITIAL 11/84

ASSOCIATES: Perkash, I Chase, RA Michalowski, S

QUADRIPLEGIA, REHABILITATION, ROBOTICS, SENSORS, MOBILITY

OBJECTIVE: The objective of the project is to enhance the utility of the Robotic Aid for the severely disabled.

RESEARCH PLAN: A number of important new capabilities will be developed for the existing Robotic Aid. As each new feature reaches technical completion. It will be tested in a clinical environment, with the participation of severely disabled users. Specific research projects are as follows: 1) omnidirectional mobility based on a unique three-wheeled design; 2) vehicle navigation based on scanning ultrasonic sensors; 3) natural language interface; 4) sensor-based collision avoidance and grasping using staggered optical proximity sensors; 5) force-controlled motion; 6) semi-autonomous modeling of the manipulation environment; 7) enhanced robot safety through implementation of a stand-alone watchdog processor and 8) user training.

METHODOLOGY: Much of the technology will be based on existing proven methods. Incorporation into the Robotic Aid will take place via custom-designed software control olgorithms. An important feature of these algorithms is their interactive nature: the disabled users will participate in determining the motion of the robot by means of spoken commands.

RESULTS TO DATE: The project is in the process of acquiring equipment. Major computational and sensor elements are being ordered. Preliminary work has been carried out in the area of proximity sensing, vehicle navigation and environmental modelling. An omnidirectional mobile base is nearing completion.

Functional Electrical Stimulation for the Prevention of Pressure Sores
LEVINE, SIMON P., Ph.D. 506 ANN ARBOR, MI
PROJECT 1
LAST REPORT, INITIAL 04/85

ASSOCIATES: Dobbins, WO

Pressure Sores, Decubitis Ulcers, Functional Electrical Stimulation (FES)

Many physically disabled individuals experience ulceration of the skin when external forces are applied over a period of time without relief. The direct cause of these sores is the restriction or cessation of blood flow (ischemia) to living tissues. These "pressure sores" (decubitis ulcers, ischemic ulcers, bed sores, etc.) are a devastating problem, especially for paralyzed indivdiuals, who are wheelchair dependent. The need for a better means to prevent pressure sores is clear. There is great motivation from both economic considerations and quality of life issues for pursuing new avenues for research on this problem.

The research plan investigates a new application of functional electrical stimulation (FES) for prevention of pressure sores. Review of the literature points out a number mechanisms by which FES might assist in the prevention of pressure sores:

1) By creating variations in seating interface pressures (and tissue configuation) which would dynamically allow blood flow to ischemic areas (a so called "immediate effect").
2) By increasing blood flow to muscle and surrounding tissue which is actively stimulated, through muscle pump activity and vasolidation (an "immediate effect").
3) By changing tissue characteristics, i.e. increased muscle bulk, vascularization, etc. ("long-term effects").

Our first experiment is a study to test the hypothesis that FES can produce seating interface pressure variations which dynamically allow blood flow to ischemic areas. This study will also be used to make preliminary determination of optimal stimulation parameters to be used in a second experiment. The second experiment tests the hypothesis that short term FES effects can help prevent pressure sore formation in quadriplegic patients. Medium (2-3 years) and long term (3-5 years) objectives include thorough investigation of conditions under which FES can be used to prevent pressure sores. These include the value of "chronic" FES, the interdependence of immediate/dynamic and chronic effects, and the range of anatomic locations and pressure sore etiologies amenable to preventative treatment with FES.

Preliminary results have been encouraging and show that substantial seating interface pressure variations (up to 15 mm Hg) can be produced using FES.

	Total Funding	Research Portion
83-	$-0-	-0-
84-	-0-	-0-
85-	$40,545	$30,545

EVALUATION OF TOTAL JOINT LOOSENING USING X-RAY PHOTOGRAMMETRY
LIPPERT, FREDERICK, M.D., Ph.D. 663 SEATTLE, WA
PROJECT 2
LAST REPORT, PROGRESS 03/85

ASSOCIATES: Veress, SA

ORTHOPAEDICS, JOINT REPLACEMENT, X-RAY PHOTOGRAMMETRY
OBJECTIVES: The purpose of this project is to develop a clinically applicable system for measuring relative motion between the components of total joint implants and the bones into which they are placed in order to evaluate the loosening or migration of the components.
RESEARCH PLAN: Radiographic markers are placed in the bone and total joint components, displacements are measured with two- and three-dimensional x-ray photogrammetry systems under various loading conditions or as a function of time since surgery.
METHODOLOGY: Research subjects are placed in a calibration framework and exposed to x-rays from two anodes, the images of the radiographic markers in the bone and components are measured on an accurate coordinatograph and their three-dimensional coordinates calculated. Changes in the relative positions of the markers with time or loading indicate looseness or migration of the total joint components.
RESULTS: The necessary components for a clinical applicable system are undergoing final testing. The calibration frames for both two- and three-dimensional x-ray photogrammetry systems have been evaluated for accuracy and proven to be able to measure spatial coordinates with an accuracy of better than (plus or minus)0.1 mm. The necessary high-accuracy coordinatograph and computer programs for analysis have been completed. Subjects who volunteered to have radiographic markers implanted at the time of their total joint replacement surgery are being followed for evidence of loosening or migration of their implants.

	$ TOTAL	Research Svcs
F/ 83	114,359	$41,647
F/ 84	$61,787	$34,508
F/ 85	$59,600	$20,348

EVALUATION OF PHYSIOLOGIC SUSPENSION FACTORS IN BELOW-KNEE AMPUTEES

LIPPERT, FREDERICK, M.D., Ph.D. 663 SEATTLE, WA
PROJECT 4
LAST REPORT, FINAL 09/84

ASSOCIATES: Burgess, EM

Below Knee Prosthesis / Physiologic Prosthesis Suspension
Stumpmusculature Training / Muscle Stabalized Residual Limbs

OBJECTIVES: Improved evaluation, training, and fitting of BK prostheses for physiologic contributions to suspension.

METHODS: We evaluated 60 definitive and 28 research prostheses with our protocols and instrumentation.

Isometric stumpmusculature training was conducted within the environment of the prosthesis socket. Tensile retention abilities were compared pre and post training.

Serial and family check sockets were produced and evaluated to define and fine tune prosthesis design guidelines.

CONCLUSIONS: Stumpmusculature can contribute to prosthesis suspension.

Physiologic suspension capacity is clinically predictable.

Isometric training within the prosthesis socket can improve physiologic suspension.

Physiologic suspension is a function of measurable stump and socket factors.

Our instrumentation provides a reasonable representation of suspension function from static measurements and accurate assessment of physiologic suspension factors, however, it's suitability for routine clinical use is limited.

Surface photogrammetry does not produce meaningful results for this research.

Tibio-fibular motion occurs during muscle activity and is constrained by the prosthesis socket.

Our guidelines for BK socket design provide improved amputee function even where the stumpmusculature's contraction potential is small. These guidelines for corraborate advanced BK prosthetics techniques and established guidelines for BK suction sockets.

Inappropriate prosthesis design prevents many amputees from gaining advantage from physiologic capabilities.

RECOMMENDATIONS: Conduct extensive clinical trials using evaluation and training protocols and socket design guidelines developed through this research.

Develop a functional evaluation (obstacle) course to test performance.

Correlate amputee response to functional questionaires with performance evaluations.

Continue to refine techniques for 3-D measurement of stump and socket factors utilizing state of the art technology.

YEAR	Funding TOTALS	Personnel Svcs
FY83	$144,859	N/A
84	$69,203	$39,521
85	18,180	$16,186

THE NATURAL COURSE OF REFLEX CHANGES FOLLOWING STROKE AND SPINAL CORD INJURY

LITTLE, JAMES W., M.D., Ph.D. 663 SEATTLE, WA
PROJECT 1
LAST REPORT, PROGRESS 07/84

ASSOCIATES: Halar, E

SPASTICITY, SPINAL CORD INJURY, H REFLEX

PROJECT OBJECTIVE: 1. To determine the temporal course of reflex change both monosynaptic and polysynaptic, after stroke and spinal cord injury (SCI), as a model of human central nervous system plasticity. 2. To correlate electrophysiologic measures of spinal reflex activity with clinical assessments of hyperreflexia as clinically useful quantitative measures of spasticity.

RESEARCH PLAN: Electrically-elicited and clinically-elicited monosynaptic H reflexes and polysnaptic withdrawal reflexes are tested serially through one year post-ictus after acute stroke and spinal cord injury.

METHODOLOGY: Maximal H-reflexes are elicited to tibial nerve electrical stimulation and recorded with surface electrodes from the soleus muscle. Withdrawal reflexes are recorded over the tibialis anterior muscle to sural nerve stimulation. Amplitude and latency measurements of the reflex evoked potentials, normalized by measurements of the direct evoked potentials, normalized by measurements of the direct evoked potential in the muscle, are the parameters measured serially after upper motoneuron lesions.

FINDINGS TO DATE: A characteristic time-course of H reflex change has been identified after complete spinal cord injury with normalized H amplitude transiently increasing between one and four weeks, accompanied by an increase in H latency. H amplitude again increases between two and five months. The increase in H/M ratio at 2 to 5 months represents an increase in H reflex amplitude rather than M response amplitude and occurs in SCI patients, both treated and not-treated with spasmolytic medication.

	TOTAL FUNDING	PERSONNEL SERVICES
83	$ 9,672	$ 9,172
84	- 32,916	$ 25,099
85	- 7,800	$ 6,000

Maxillofacial Restorative Materials and Techniques
LONTZ, JOHN F., Ph.D. 460 WILMINGTON, DE
PROJECT 3
LAST REPORT, PROGRESS 08/84

ASSOCIATES: Schweiger, JW

MAXILLOFACIAL PROSTHESES, POLYDIMETHYL(PDM)SILOXANE, PERFORMANCE STANDARDS, BIOCOMPATIBILITY, TISSUE CULTURE TEST, ASTM STANDARD, FDA APPROVAL

Objective. To provide standards for safe and effective maxillofacial orofacial prosthetic devices fabricated from silica-free polydimethylsiloxane for approval by the Food and Drug Administration for all VA-wide clinical needs.

Research and Clinical Development Plan. The project has devised and pursued a comprehensive development plan through multiphasic projects comprising product development from pure form of polydimethyl(PDM)siloxane to VA-wide clinical praticipation plan concurrent with safe and efective testing by performance standards and human relevant tissue culture testing. The plan is being augmented by technology transfer to a commercial venture.

Findings, Results, and Conclusions. PDM siloxane represents a major improvement over commercially available, so-called medical grade silicone, the term being synonymous with a composition filled with fumed silica as reinforcing component. While such silicones serve effectively in many applications, it was necessary to (a) eliminate the spalling failure of silicones, (b) increase tear resistance, and (c) modify the extensile characteristics to approximate that of living tissue. For such needs, the sustained research attained all these improvements along with cell culture testing for safety to specific orofacial tissues now proposed for ASTM standards. FDA approval for pre-market commercialization has been obtained for several devices.

The merits of PDM siloxane compared to commercial silicones and several other prosthetic materials have been further affirmed by VA-wide clinical trials reported from 35 percent of the 69 participating clinics with over 500 clinical cases with no deficiencies or risk of safety. Particularly noteworthy is the successful use in the area of facial implants needed for anatomical corrections with Downes pediatric syndrome cases utilized in a Hadassah (Israel) clinic.

Presently the project is preparing procedural details and quality control standards for FDA on Good Manufacturing Procedure and FDA Good Laboratory Practices in the on-going transfer technology. The research and clinical development has been extended to a series of projects that include separation of growth factors in processed human serum, for the cytotoxicity test system, assessing wound healing pharmaceuticals, and developing improved lined and sanitized dentures based on product variation on PDM siloxane, a need crucial to our ageing veteran population.

FY'83	FY'84	FY'85
$114,000	$31,339	-0-

Salaries of project employees not available for FY'83. For FY'84, $29,073 was provided in salaries.

The Application of Micro-Computers for the Treatment of Aphasic Adults

LOVERSO, FELICE L., Ph.D. 543 COLUMBIA, MO
PROJECT 1
LAST REPORT, PROGRESS 12/85

ASSOCIATES: Prescott, TE

APHASIA, MICRO-COMPUTER, COMMUNICATION, ACTOR-ACTION-OBJECT COMBINATIONS

OBJECTIVES: The purpose of this investigation is to create a computer based aphasia rehabilitation program using verbs as pivots and applying this treatment to aphasic patients utilizing a single case design.

RESEARCH PLAN: Aphasic patients who have demonstrated stable language skills, suffered a single left cortical insult, are six-months post onset, and are at or above the 50%-ile on the Porch Index of Communicative Ability will receive a minimum of a one hour computer treatment session four times weekly. Initially, each patient will receive five treatment probes for each of the six treatment levels which range from copying actor plus action combinations to self generation of actor-action-object combinations both verbally and graphically. Each level will consist of 30 action stimuli and wh-cues randomly presented to elicit two and three word utterances and sentences. Once treatment begins daily probes on untreated levels will be made so as to measure the effects of treatment at one level on those levels not yet focused on in rehabilitation. Weekly maintenance probes will be administered to treatment levels which criterion has been reached as well as monthly external standardized language tests to measure the effects of treatment on overall communicative functioning.

METHODS: Each subject, after receiving baseline probes at each level and standardized language tests will begin the program at the initial level and continue at that treatment level until criterion is reached (three times 90% accuracy). After criterion at a given level is reached initiation of the next treatment level will begin. Daily treatment probes on untreated levels, weekly maintenance proves on completed levels & monthly standardized language tests will remain constant for all subjects studied.

RESULTS TO DATE: We have completed the computer programming of the six treatment levels and have applied this protocol to three patients. The findings from our patients suggest that using micro-computers were effective and this treatment approach had significant positive effects on overall language functioning. A portion of this work has been reported to the American Speech-Hearing-Language Association's Annual Meeting in San Francisco, California, November 1984.

	Total Funding	Renewal Basis
83	-0-	-0-
84	-0-	-0-
85	$31,625	-0-

Design of Bathrooms, Bathroom Fixtures and Controls for the Able-Bodied, Disabled and Elderly - RR&D #46

MALASSIGNE, PASCAL M. 508 DECATUR, GA
PROJECT 1
LAST REPORT, PROGRESS 12/84

ASSOCIATES: Bostrom, JM

SHOWER FIXTURES, QUADRIPLEGIC, ROLL-IN SHOWERS, PROTOTYPE, ACCESSIBLE, BATHING

Objectives: This project will test, evaluate and recommend specific shower designs for disabled persons. To do this, four shower fixtures will be tested--four prototypical showers developed by Bostrom and Malassigne: 1. a cushioned shower prototype; 2. a prototype with two integral facing seats; 3. a stall shower with wall seat, and 4. a two-piece roll-in shower.

Research Plan: The evaluation of the four fixtures will focus primarily on disabled persons taking showers. Because each prototype has been designed for use by one primary disabled group (e.g. paraplegics, quandriplegics, etc), not all of the subjects will be able to use all of the fixtures. For example, quandriplegics who cannot transfer will only be able to use the roll-in shower.

Methods: Quantitative and qualitative analysis is based on 3 dimensions: user performance, user safety, accomplishment of bathing tasks. (Task accomplishment will be measured by success or failure of tasks, user performance, time-motion studies and user safety by behavioral observation). User satisfaction is determined from a post trial interview.

Results: To date, 32 subjects have participated in the evaluation of the showers. Subjects have possessed various dsabilities (quadriplegia, arthritis, hemiplegia, muscular distrophy, etc.) and have been recruited from Atlanta area veterans and from other area medical and rehabilitation centers. Testing has shown that three of the shower designs, the cushioned shower, the stall shower with seat and the two-piece roll-in shower are safely usable by a wide variety of people with physical disabilities. Analysis of data has also indicated that minor design modifications are necessary to correct deficiencies in drainage, shower curtain operation, and limb support. Redesign and fabrication of new designs will be done in early 1985. One additional finding is that one-half of the subjects are currently unable to bathe in a normal manner, and depend on infrequent (once or twice weekly) sponge baths as the only method of body cleaning.

	Total Funding $	Personnel Share $
FY83	$ -0-	-0-
FY84	$124,302	$59,323
FY85	$130,234	$51,396

Comprehensive Management of Upper and Lower Extremity Amputation
MALONE, JAMES M., M.D. 678 TUCSON, AZ
PROJECT 5
LAST REPORT, PROGRESS 03/85

Amputation, Prosthetics, Xenon Skin Blood Flow, Rehabilitation

Plan: The purpose of this project is to continue to develop techniques for preoperative amputation level selection, to develop techniques for building inexpensive temporary prostheses, to evaluate the role of immediate post-surgical fitting for upper extremity amputation, and to investigate the role of elective amputation for patients with neurologic dysfunction.

Methods: Amputation level selection is performed using doppler ankle pressures, intradermal Xenon-133 skin blood flow, transcutaneous small pO(sub2) and pCO(sub-2) and the lasser doppler. Prostheses are fitted at the time of lower extremity surgery. Between surgery and fitting of permanent prostheses, all patients are provided with temporary light-weight inexpensive prostheses which are modified as needed. Elective amputation with prosthetic fitting has been performed in patients with neurologic dysfunction due to brachial plexus injury or patients with orthopedic complications who require amputation for management of their problem.

Results: 1) Of all modalities tested, Xenon skin blood flow continues to provide the most discriminate end point for amputation level testing.

2) Transcutaneous pO(sub-2) and pCO(sub-2) may have a role in amputation level selection and in evaluation of reflow phenomena after vascular reconstruction.

3) We have published and taught our techniques for building inexpensive light-weight prostheses at major regional and national prosthetic educational programs.

4) For patients with preganglionic brachial plexus lesions, early amputation with elective shoulder fusion and prosthetic fitting has become the treatment of choice. For patients with chronic osteomyelitis, ankle or knee problems which are not solvable through fusion of joint replacement, lower extremity amputation is a useful rehabilitative procedure.

5) The comprehensive management of upper and lower extremity amputation continues to result in extremely high rates of rehabilitation. During the last year this research program has resulted in four chapters, three manuscripts and eight presentations at national meetings.

	Total Funding	Personnel Svcs
83	$ 153,339	$ 36,756
84	$ 144,891	$ 50,823
85	$ 64,435	$ 24,898

Biomechanical Comparison of Total Elbow Replacement Prostheses
MANN, RONALD J., M.D. 660 SALT LAKE CITY, UT
PROJECT 1
LAST REPORT, FINAL 07/85

ASSOCIATES: Daniels, AU

elbow, prosthesis, biomechanics, design

Research objectives were to compare and analyze the biomechanics of existing total elbow prostheses and suggest design solutions to biomechanically-related performance problems identified. Manufacturers donated prostheses for study. Prosthesis geometry and ability to replicate normal elbow mechanics were evaluated using standard dimensional and angular measuring devices. The surgical literature was searched and reviewed to identify relationships between design parameters and reported clinical failures modes.

Nine "regular" or "medium" prostheses (Coonrad II, Pritchard Mark II, Stanmore, Schlein, Triaxial, Mayo, Capitello-Condylar, London and Wadsworth) were compared. Eight biomechanical parameters were measured. Also, after studying cadaver specimens, a geometric relationship was identified to assess the ability of each prosthesis to replicate the flexion/extension center of rotation of the normal elbow.

A wide range of biomechanical parameter limit values were found. These results were presented recently (Trans. O.R.S. 10: 100, 1985). Generally, these prostheses are either quite unconstrained to prevent loosening and therefore limited in application, or substantially constrained and subject to early failure die to forces transmitted from the constraints to the prothesis/bone interface.

To complete this project, a prototype prosthesis was designed, fabricated and subjected to preliminary mechanical evaluation. The goal was a moderately constrained, widely applicable design less likely to loosen. The unique feature is a humeral component anti-loosening "bearing". For a detailed description see J.C. Serbousek, (Biomechanical Evaluation of Current Elbow Prostheses and Description of a New Design, M.S. Thesis, Bioengineering Department, University of Utah, June 1985).

	TOTAL	Personnel Svce
FY 83	$64,590	$44,349
FY 84	$6,946	$4,800
FY 85	-0-	-0-

Walking restored in paralyzed man using electronic orthotics
MARSOLAIS, ERNEST B., M.D., Ph.D. 541 CLEVELAND, OH
PROJECT 4
LAST REPORT, PROGRESS 05/85

ASSOCIATES: Chizeck, HJ Ko, W Mansour, JM

Functional electrical stimulation, closed-loop control, neuromuscular orthotics, artificial walking, paraplegia

OBJECTIVES: To refine the existing neuromuscular orthotics system to yield smoother performance, improved stability, specific functional activity, reduced fatigue; and to provide it in an implantable form.

PLAN: We will (1) improve the individual muscle performance by improving implantation techniques and electrode design; (2) improve stability and smoothness of motion through the implementation of closed-loop controllers, using an improved mathematical model of human gait; (3) continue to improve the external controller which will be compatible with four 8-channel implantable units being developed under a related project; (4) evaluate sensor needs and design the ones necessary for the closed-loop system.

METHOD: We will (1) evaluate intramuscular, cuff and subfascial electrodes; (2) test controller designs with computer simulation prior to implementation and compare to the open-loop system; (3) miniaturize the best controllers, interface it with existing sensors and integrate it into the current portable stimulators for use outside the laboratory.

FINDINGS: Implantation of hip extensors and abductors and planter flexors; and new programming of muscle stimulation sequences to incorporate action of these muscles has resulted in a fivefold increase in maximum paraplegic walking speeds. Patients have developed increased muscle forces, fatigue resistance and stability, allowing them to walk farther. Closed-loop control of ankle and knee angles can improve standing stability, resistance to perturbations and can reduce the level of stimulation during standing. A computer program has been developed to calculate the constraint forces and moments of models which simulate human walking. There is a need for a new stimulator with a larger memory to allow programming of additional functions; and provide interpulse interval modulation of stimuli to increase the response of muscle. There remains a need for an improved muscle model.

CLINICAL RELATIONSHIP: Electrical stimulation is being used to provide six subjects with systemic functional motions, which are being coordinated to allow limited functional activities.

F.Y '83	F.Y '84	F.Y '85
$ [illegible]2,510	$548,575	$686,429

The amount of personal service dollars provided to support this study is as follows:

F.Y 83 $119,910
F.Y 84 $288,120
F.Y 85 $361,290

TRANSCUTANEOUS OXYGEN TENSION AS A PREDICTOR OF WOUND HEALING

MATSEN, FREDERICK A. III, M.D. 663 SEATTLE, WA
PROJECT 1
LAST REPORT, FINAL 09/83

ASSOCIATES: Wyss, CR Burgess, EM

PERIPHERAL VASCULAR DISEASE, TRANSCUTANEOUS OXYGEN TENSION, DIABETES, AMPUTATION.

Objective of Project: To evaluate the application of transcutaneous oxygen tension measurements as predictors of the healing of spontaneous ulcers and amptuation incisions in patients with peripheral vascular insufficiency.

Research Plan: Seattle Veterans Administration patients requiring amputation because of peripheral vascular insufficiency receive standard vascular evaluation and also segmental transcutaneous P0(sub-2) measurements. The preoperative results are correlated with the subsequent healing of the amputation and ulcers.

Methodology: The non-invasive transcutaneous P0(sub-2) sensor developed by Radiometer and the eight channel instrument developed by the Departments of Orthopaedics and Bioengineering at the University of Washington are used to make measurements. The data are analyzed using a computerized data base and analysis system (system 1022).

Findings, Results, or Conclusions to Date: Data from the legs of over 270 patients with peripheral vascular disease, half of whom have diabetes, indicate that: 1. Patients with segmental TcP0(sub-2) values less than 22 mmHg are more likely to have ulcers, to have rest pain, or to require an amputation within two months; furthermore, amputations performed through an area where the TcP0(sub-2) is less than 20 mmHg had a 50% healing rate while amputations through an area where TcP0(sub-2) was greater than 40 mmHg had a 100% healing rate. 2. A significant number of diabetic patients have ulcers in areas of high TcP0(sub-2) values suggesting these ulcers may not result from ischemia. 3. TcP0(sub-2) values are a statistically better discriminator among the various severities of vascular insufficiency than are ankle-arm systolic pressure indices. 4. Papers: "Transcutaneous Oxygen Tension Measurements on the Limbs of Diabetic and Nondiabetic Patients with Peripheral Vascular Disease", Surgery (in press). "The Relationship of Transcutaneous P0(sub-2) and Laser Doppler Measurements in a Human Model of Local Arterial Insufficiency", Surgery, Gynecology & Obstetrics (in press).

	TOTAL	Personnel Svcs
83 -	$59,801	$40,346
84 -	$143,791	$82,636
85 -	$84,974	$29.801

Predictive Value of Transcutaneous PO(sub 2) in Peripheral Vascular Disease

MATSEN, FREDERICK A. III, M.D. 663 SEATTLE, WA
PROJECT 2
LAST REPORT, PROGRESS 01/85

ASSOCIATES: Wyss, CR Olerud, J Pecoraro, RE

Peripheral vascular disease, diabetes, transcutanenous oxygen tension, amputation, reconstruction, ischemia

Objectives: To evaluate the application of transcutaneous oxygen tension measurements as predictors of the healing of spontaneous ulcers and amputation incisions in patients with peripheral vascular insufficiency.

Research Plan: Seattle Veterans Administration Hospital and patients requiring amputation or vascular reconstruction because of peripheral vascular insufficiency receive standard vascular evaluation and also segmental transcutaneous PO2 measurements. The preoperative results are correlated with the subsequent healing of the amputation and ulcers. Postoperative vascular reconstruction results are correlated as well. The relationship between peripheral sensation, clinical condition, and skin perfusion is also under study.

Methodology: An eight-channel noninvasive transcutaneous oxygen monitor, developed under this project in collaboration with Department of Electrical Engineering at the University of Washington, is used for making the measurements. The data are stored and analyzed using a computerized data-base and analysis system (system 1022).

Findings, Results, or conclusions to Date: Data from the legs of over 350 patients with peripheral vascular disease, a third of whom have diabetes, indicates that: (1) patients with segmental TcPO2 values of less than 20 mmHg are more likely to have rest pain, ulcers, or to need an amputation within two months; furthermore, any amputation performed through an area where the TcPO2 is less than 20 mmHg is much less likely to heal. (2) The effect of chronic limb ischemia on peripheral sensation was relatively weak when compared to the effects of diabetes and alcoholism. (3) Cutaneous ulcers were more common in those nondiabetes patients with poor sensation, whereas ulcers in diabetic patients were unrelated to the integrity of peripheral sensation.

Predictive Value of Transcutaneous PO(sub 2) in Peripheral Vascular Disease

MATSEN, FREDERICK A. III, M.D. 663 SEATTLE, WA
PROJECT 2
LAST REPORT, PROGRESS 01/85

ASSOCIATES: Wyss, CR Olerud, J Pecoraro, RE

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Ferrographic and Biochemical Analysis of Wear Particles in Human Joints (title change)
MEARS, DANA, B.M., B.Ch. D.D.S 646 PITTSBURGH, (UD), PA
PROJECT 1
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Evans, CH

ARTHRITIS, WEAR PARTICLES, ENZYMES, FERROGRAPHY

Our first short-term objective in the project was to identify those components of cartilaginous wear particles which produce cellular activation and contribute to arthritic changes. Investigation involving tissue culture experiments in vitrc & animal studies in vivo have confirmed the importance of cartilage proteoglycans as mediators of inflammation & arthritic changes. Recent estimates of the proteoglycan content of human synovial fluid during rheumatoid & osteoarthritis are compartible with the hypothesis that our experimental findings reflect the pathophysiological condition of human arthritic joints.

The second short-term objective, to evaluate catabolin release in response to wear particles, has also been met. As we saw for collagenase, synovial cells secrete more catabolin when challenged with wear particles.

Finally, we are continuing to look at further selected patient groups by ferrography, as planned. Particular attention is being applied to rheumatoid synovial fluid, which has hitherto received little analysis by ferrography. Our preliminary studies show that ferrograms prepared from rheumatoid synovial fluids are strikingly different from those prepared from the fluids of non-rheumatoid joints. Wear particles are few in number, but a heavy precipitate of magnetized cells is recovered.

	TOTAL	Research Svce
FY'83	$ 46,069	$10,003
FY'84	$ 89,523	$35,357
FY'85	$ 52,677	$11,450

Development and Improvement of Running Skill in Unilateral Below Knee Amputees

MILLER, DORIS I., Ph.D. 663 SEATTLE, WA
PROJECT 1
LAST REPORT, FINAL 09/84

ASSOCIATES: Passer, MW Burgess, EH

Biomechanics, running, amputees, psycho-social, ground reaction, self-esteem

OBJECTIVES: The purpose of the project is (1) to design, implement and assess procedures for developing and improving the running gait of unilateral below-knee amputees who have lost limbs as the result of trauma, carcinoma or congenital abnormality, as the basis for encouraging and enabling them to pursue physically active lifestyles; (2) to gain further insight into the biomechanical factors influencing successful running performance in this population; and (3) to provide insight into the effects of running skill acquisition on self-esteem and body-concept of participants, and the role of psychological and social factors in mediating the degree of running skill proficiency attained by participants.

RESEARCH PLAN: Subjects receive a physical and prosthesis evaluation; complete psycho-social questionnaires; have their running skill, lower extremity muscle strength and cardiovascular efficiency evaluated. Based on these initial tests and their own goals subjects participate in an individualized program of prosthetic modification, running training, sports skill instruction and exercise for a period of approximately three months. Periodic and final assessments of their progress are made.

METHODOLOGY: On-line computer data collection from force platform and Cybex II are used. Running skills are filmed at 100 fps with a Locam camera at the same time that ground reaction forces are recorded. A three-dimensional (DLT) work-energy analysis was also conducted on a limited number of subjects.

FINDINGS: To date, 13 lower extremity amputees have been involved in various aspects of the project. Those engaged in the running-exercise-skill development program have all responded favorably and have improved their running performance. The use of the treadmill with emphasis on shortening the running step has successfully reduced or completely eliminated the tendency to maintain an excessively extended residual knee during stance on the prosthesis. Final Psycho-social assessments of individuals who have completed the program indicate a number of positive changes perceived in running skill and in life in general as a result of participation in the study. Administrative Final Report. 600 page final report submitted by Dr. Miller to RR&D, VACO per contract V663P-1336.

	FUNDING	PERSONNEL SVCS
FY '83	$25,000	N/A

Myoelectric Analysis of Spine Function (title change)
MOONEY, VERT, M.D. 549 DALLAS, TX
PROJECT 2
LAST REPORT, PROGRESS 09/85

ASSOCIATES: Kondraske, GV Mayer, TG Carmichael, TW
Deivanayagam, S

Muscle fatigue; myoelectric signals; spectral analysis; low back pain

OBJECTIVES: The overall objective of this project is to improve current noninvasive objective methods and equipment for practical clinical assessment of disability and rehabilitation of trunk support musculature function and fatigue in patients with low back pain.

PLAN: Myoelectric signals from erector spinae muscles will be measured during isometric back extension exercise and analzyed for voltage and frequency spectral characteristics. Studies of normals will be conducted to evaluate and improve test result quality control and to establish a normal data base. Patients will be tested to determine the clinical utility of these methods by quantitatively documenting disability and effects of rehabilitation.

METHOD: Bipolar surface electrodes will be used to detect the myoelectric signals from erector spinae muscles of subjects performing isometric exercise on a mechanical trunk strength testing machine. Existing computerized systems will compute fatigue using the linear decay measure of mean power frequency changes. A prototype micro-processor-based device will be designed and constructed which will automate clinical testing and analysis procedures.

SIGNIFICANCE: A preliminary normal data base of 34 normals has been collected which exhibits good correlation (r=0.86) between exercise load level and linear decay fatigue measure. A study of 30 patients with low back pain has shown that a majority of patients have greater fatigue rates than normals at the same load levels. By refining methods and collecting further normal and patient data, it is believed that this objective measurement of muscle function will be useful in determining the effectiveness of rehabilitation programs for low back pain patients.

F/Y '83	F/Y '84	F/Y '85
$41,957	$83,660	$87,092

Funding for Research Service is as follows

F/Y 83 $13,202
F/Y 84 $4,961
F/Y 85 $29,289

Total Hip Implant Biotelemetry
MORELAND, JOHN, M.D. 691 WEST LOS ANGELES (WADSWORTH DIV
PROJECT 2
LAST REPORT, PROGRESS 11/84

The objective of this work is the design and development of a special total hip component which will contain within it a miniaturized biotelemetry system capable of broadcasting signals received from strain gages mounted within the neck of the prosthesis. The present proposal is directed toward the design of the implant, refinement of the telemetry system, development of the power induction system, assembly of a data recovery system, a mechanical testing program designed to assure the structural integrity of the implant and finally a leak-test program to ensure the hermeticity of the total system. In summary, the project is aimed at assuring that the implant will meet the requirements for a patient implant which will be the subject of a follow-up proposal. Work has begun on the implant fabrication.

	Total Funding	Personal Serv
83	$39,160	$39,160
84	$49,407	$40,407
85	$182,900	$48,182

Myoelectrically Controlled Above Knee Prosthesis
MOSKOWITZ, GORDON, D. Ph.D. 642 PHILADELPHIA, PA
PROJECT 1
LAST REPORT, PROGRESS 08/85

ASSOCIATES: Hillstrom, H Triolo, R

The need exists for active volitionally controlled above knee (A/K) prostheses which are more easily controlled by the amputee. Currently, control of lower limb prostheses has been largely limited to preprogrammed, passive devices which are awkward and difficult to control. Currently, the most popular means of passive control is the use of fluid damping mechanisms at the knee joint. Active volitional control of a prosthesis permits continuous adjustment to changing gait conditions, decreasing metabolic energy usage, and the ability to respond to extraordinary events such as stumbling.

A myoelectrically controlled A/K prosthesis is under development at this laboratory that provides greater conscious and subconscious active control in gait and nongait activities. This prototype prosthesis has three principal operatin subsystems: a myoelectric signal processor, a controller and a hydraulic/pneumatic (H/P) actuator.

The myoelectric signal processing that we employ includes spatial pattern recognition and time-series methods. At present, it is believed that the patterns o EMG used for control are nonstationary and, therefore, may compromise controller performance and/or require more energy, effort and concentration on the part of the user over time. The requirements are relevant specifications for adaptive spatial pattern recognition are being quantified.

A. Modelling and Simulation of Hydraulic/Pneumatic Actuator

Two design configurations were developed. The first system (a) employs four hydraulic valves, one liquid-air reservoir, one actuator piston and one liquid sump. The second system (b) consists of an additional pneumatic valve and a split liquid-air reservoir. The second system (b) is under construction.

B. Time Series Control Studies

Spectral changes in the surface EMG have been characterized by autoregressive (AR) models and used to detect the direction of limb movement.

Recent progress has been made in estimating muscle force as well as limb function from a time-series system. Time-series processors have, in the past, yielded only binary decisions. This research is unique in its attempt to develop a signal from a time series system which is proportional to force and in its attempt to develop a signal from a time series system which is proportional to force and simultaneously specify magnitude and direction of movement. The work in process has attempted to estimate muscle force from multiple channels of serially dependent EMG data by first prewhitening the EMG with the AR filters used for function classification, obtaining a polled estimate of prewhitened signal variance, and fitting a power law relationship to the variance signal and force. Testing and

	Total Funding	Personnel Services
F/83	$14,000 -	$ -0-
F/84	93,206 -	$ 82,298
F/85	108,154 -	$ 96,466

evaluation of the complete myoprocessor is underway.

C. EMG Pattern Control Studies

Data qualification procedures have been applied to raw, processed, and patterns of processed EMG. In addition, linear discriminant function (LDF) coefficients from static spatial pattern recognition limb function classifiers, and estimated and actual joint moments were also analyzed. Stationarity of both the means and variances of the aforementioned variables was examined on the second, minute, and hour scales.

The ability of the static spatial pattern recognition system to recognize the intended limb function of the amputee, in terms of force magnitude and direction, has indicated adequacy of the fundamental model structure. Current studies in adaptive spatial pattern recognition methods have been aimed at transforming the minute and hour scale nonstationarity of the estimated joint moment mean to a stationary space, (such as the observed joint moment mean).

Thermographic/Spectroscopic Comparison of Soaks, Exercise and Trental(R) on Diabetic Feet

MOSS, CATHRYN, D.P.M. 662 SAN FRANCISCO, CA

PROJECT 1
LAST REPORT, INITIAL 09/85

Liquid crystal thermography, magnetic resonance spectroscopy, diabetes, ischemic ulcers, peripheral vascular disease, trental, exercise, foot soaks

Diabetic foot ulcers, through infection and non-healing, cause significant disability and limb loss on an expanding diabetic population. Multiple factors, i.e. vascular insufficiency, neuropathy, metabolic abnormalities and structural deformity, have been investigated as contributing to tissue breakdown in the diabetic foot. However, the relative role of each of these factors is unclear. Thus far, no specific criteria have been established to assess the progress of diabetes-related foot diseases. It would seem both financially and medically prudent to develop non-invasive diagnostic tests to identify patients "at risk" of ulceration in order to facilitate the earliest medical intervention.

The objective of this project is to delineate any thermographic or spectroscopic differences within the diabetic population that could be used to screen out patients "at risk" of ulceration.

Using liquid crystal thermography and magnetic resonance spectroscopy, this project will study vascular reactivity in skin and the level of ischemica in muscle in face of various therapeutic maneuvers. This project will evaluate forty patients equally divided into four population groups. Each patient will be interviewed and a standard questionnaire including pertinent medical history and physical examination of the foot completed. Based on this information, patients will be placed in one of four study groups:

1. non-diabetic controls;
2. diabetic patients with no prior history of foot ulceration;
3. diabetic patients with a prior history of foot ulceration but without active foot ulcers; and
4. diabetic patients with active foot ulceration.

Thermographic evaluation of all patients will be completed before and following three different therapeutic maneuvers: 1. exercise; 2. uniform warming and 3. an eight week therapeutic trial of Trental. Magnetic resonance sepctroscopy will be completed on a small set of patients in like manner distributed among the groups, but evaluating only: exercise and Trental.

The database will be analyzed using the Clinfo statistical package to determine how one population differs from the other and how exercise, warming and Trental affect thermographic and spectroscopic patterns. It is hoped that this information will aid in the development of a prospective index in the overall assessment of the diabetic foot.

	Total $ Funding	Personal Services
83	$ -0-	$ -0-
84	$ -0-	$ -0-
85	$ 6,058	$ 5,548

Human functional performance: Normal and neuro-musculo-skeletal disorders (new title)
MURRAY, M. PATRICIA, Ph.D. 695 MILWAUKEE, WI
PROJECT 1
LAST REPORT, FINAL 10/85

ASSOCIATES: Seireg, AA Brewer, BJ Gore, DR

GAIT, KINEMATICS, EMG, NORMAL WALKING SPEED, TREADMILL, ROTATION-PLASTY, MUSCLE STRENGTH

PROJECT OBJECTIVES: To obtain a deeper understanding of functional performance in persons with neuro-musculo-skeletal disabilities and in normal persons.

PLAN: To use normal standards of functional performance (gait, EMG, strength, posture, etc.) as a basis to compare the function of patients with selected neuromusculo-skeletal disabilities. To continue to investigate changes in EMG and kinematics in normal persons under various walking conditions.

METHODS: Interrupted-light photography to measure the kinematics of gait; EMG to monitor muscle activity; dynamometers to measure strength; force platforms to measure postural steadiness and stability.

RESULTS REACHED TO DATE: Since the report of 2/85, two studies accepted for publication have been published (1,2). A third study has been accepted for publication (3). The latter study measured the walking performance of 35 men with unilateral knee pain and no other disability and compared their performance with that of normal men. The following antalgic maneuvers were found to be common to the gait of these patients: slow and uneven forward motion with lateral lurching abnormalities in the displacement patterns of most body segments. Subnormal knee motion was found during the stance and swing phases. This study points out the gait factors of most value to assess in gait studies of treatment methods aimed at decreasing knee pain.

There are no other studies initiated by Dr. Murray in progress at this time.

PUBLICATIONS:

(1) Murray MP, Mollinger LA, Gardner GM and Sepic SB: J Orthop Research 2:272-280, 1984.

(2) Murray MP, Jacobs PA, Gore DR, Gardner GM and Mollinger LA: J Bone Joint Surg 67A:392-399, 1985.

(3) Murray MP, Gore DR, Sepic SB, and Mollinger LA: Clin Orthop 199: 48-56, 1985.

	Total Funding	Personnel Svc
F/83	$48,000	N/A
F/84	$ -0-	—
F/85	-0-	—

Fluorescein Diagnosis and Stump Wrapping in Lower Limb Amputations
NEUFELD, GORDON R., M.D. 642 PHILADELPHIA, PA
PROJECT 150
LAST REPORT, INITIAL 11/84

This project was previously reported as Dr. David SILVERMAN's and Dr. Gerald WOLF's project #150.

The goal of this randomized controlled clinical trial of patients with peripheral vascular disease scheduled to undergo lower limb amputation is to reduce the rate of reoperation or revision by assisting clinical judgement in determining the site of amputation and determining if early or late compression wrapping of a stump improves healing and speeds rehabilitation. The objective is to utilize perfusion fluorometry, a new diagnostic technique that can accurately separate viable from non-viable tissue. Eligible patients who have previously been randomized to fluorescein diagnosis (experimental) or clinical judgement (control) will then be further randomized to compression wrapping on the operating table (experimental) or wrapping at seven days post-operation (control). Thus two important problems regarding diagnosis treatment and rehabilitation of patients who undergo amputation can be dealt with by a single study and study population.

	Total Funding	Personnel Services
83-	$66,094	$52,918
84-	$41,464	$34,956

Fluorescein Diagnosis and Stump Wrapping in Lower Limb Amputation

WOLF, GERALD L., M.D., Ph.D. 642 PHILADELPHIA, PA
PROJECT 150
LAST REPORT, FINAL 11/84

The goal of this randomized controlled clinical trial of patients with peripheral vascular disease scheduled undergo lower limb amputation is to reduce the rate of reoperation or revision by assisting clinical judgement in determining the site of amputation and determining if early or late compression wrapping of a stump improves healing and speeds rehabilitation. The objective is to utilize perfusion fluorometry, a new diagnostic technique that can accurately separate viable from non-viable tissue. Eligible patients who have previously been randomized to fluorescein diagnosis (experimental) or clinical judgement (control) will then be further randomized to compresion wrapping on the operating table (experimental) or wrapping at seven days post-operation (control). Thus two important problems regarding diagnosis treatment and rehabilitation of patients who undergo amputation can be dealt with by a single study and study population. This study is terminated under this investigator--Dr. Gordon NEUFELD will report this project in the future.

210/Morphological and Clinical Studies of Microwounds in Ischemic Human Tissues
OLERUD, JOHN E., M.D. 663 SEATTLE, WA
PROJECT 1
LAST REPORT, PROGRESS 04/85

ASSOCIATES: Odland, G Matsen, F Wyss, C
Burgess, E

WOUND HEALING, MICROWOUND, TRANSCUTANEOUS OXYGEN TENSION (TCPO2), PERIPHERAL VASCULAR DISEASE (PVD)

Objectives: The purpose of this project is to study in a systematic fashion morphological and clinical features of small standardized wounds created on the lower extremities of patients with severe peripheral vascular disease (PVD) necessitating amputation.

Research Plan: The wounds are created with a Simplate II bleeding time device under sterile conditions at locations immediately distal to the planned site of amputation and at a variety of clinically and biologically relevant time periods for the study of wound healing. Wounds are examined clinically immediately prior to amputation and then excised from the amputation specimen and fixed for morphological studies.

Methodology: Standard techniques for tissue fixation, sectioning, and evaluation of all samples by light microscopy and of selected samples by transmission and scanning electron microscopy are used. Morphological events of healing and then compared with forearm wounds of young adults from previous studies and leg microwounds from age-matched controls. Transcutaneous oxgyen tension (TCPO(sub-2)) at the site of microwounds and the clinical appearance of the microwounds the outcome of the amputation and a variety of risk factors for PVD, such as smoking, diabetes and hypertension are also correlated with microwound healing.

Findings to date: During the past year seven additional patients have had microwounds created prior to amputation and ten normal elderly subjects have had microwounds created and biopsied to serve as age-matched controls for the amputation patients. In addition to the morphological studies of the normal and abnormal wound tissue, immunohistochemical studies have also been performed on all normal and selected abnormal wounds. The normal subjects have wound repair which is clearly more advanced than patients undergoing amputation but it is significantly more delayed than the normal yound adult forearm microwounds.

	Total Funding	Personnel Svcs
83	$59,362	-0-
84	$65,322	-0-
85	$76,182	$26,624

Mechanism of Cervical Spine Injuries

PANJABI, MANOHAR M., Ph.D. 689 WEST HAVEN, CT
PROJECT 1
LAST REPORT, PROGRESS 12/84

Injuries of the cervical spine have a significant impact on society. It is estimated that the cost of cervical cord injuries in 1974 in the U.S. alone was $760,000,000. In 1983 there were more than 11,000 spinal cord patients being cared for at the VA Hospitals at a cost of $132,000,000. Little is known about the basic mechanism that produces these injuries. Objectives of our research are studying the instability of the cervical spine before and after injury and the encroachment of the spinal canal, and, therefore, the potential spinal cord injury.

The method utilizes three vertebrae fresh cadaveric cervical spine specimens. In a specially constructed apparatus, high speed loads are applied to produce spinal injury. Forces are measured and the deformation of the specimen is recorded with a high speed movie camera. The data is analyzed with the help of computer. Three-dimensional stability is measured as well as roentgenographic studies including CT Scan, are conducted before and after the injury production.

The apparatus the load cell have been designed and manufactured. Experiments are being conducted now to calibrate the load cell. Several fresh cadaveric dog spines have been prepared for testing.

The significance of the study will be in three different areas. It will aid in determining quantitatively the spinal instability. Each type of spinal injury will be related to the encroachment of the spinal canal and, therefore, the potential risk for spinal cord injury. Finally it will provide the basic understanding of mechanisms of spinal injuries which is needed for optimum treatment and caring of the spinal injury patient.

	Total Funding	Rehabilitation Services
83	$ 108,951	$ 61,191
84	$ 100,182	$ -0-
85	$ 64,398	9,398

Effects of Low Back Pain Treatment Modalities on Lumbar Facet Loading

PATWARDHAN, AVINASH G., Ph.D. 578 HINES, IL
PROJECT 2
LAST REPORT, INITIAL 08/84

ASSOCIATES: Lorenz, MA Boscardin, JB Knight, GW
Hollyfield, RL

LOW BACK PAIN, CHYMONUCLEOLYSIS, DISCECTOMY

The specific objective of the proposed study is to obtain data describing alterations in the load bearing characteristics of the lumbar facet joints following discectomy and chemonucleolysis. The study will quantify facet loads at the altered segment as well as at the levels immediately above and below. These data will be generated as a function of the treatment modality, physiologic load type, and degree of lumbar lordosis.

These data will be acquired by testing fresh cadaver lumbosacral spine (L1-S1) specimens. The treatment modalities will be simulated at the L4-5 disc. Measurements of contact area and normal (orthogonal to the facet surface) stress distirbution, will be made at the L3-4, L4 and L5-S1 facet joints using Fuji Prescale pressure sensitive film

The data analysis will identify any combination of load type & magnitude, segment level, body posture, & treatment modality for which the load bearing characteristics of the facet joints are significantly altered from normal.

	Total Funding	Personal Services
	$	$
83	-0-	-0-
84	-0-	-0-
85	$150,092	$57,890

Biochemical Study of Spinal Fusion and Its Effect on Free Segments
PATWARDHAN, AVINASH G., Ph.D. 578 HINES, IL
PROJECT 1
LAST REPORT, PROGRESS 08/84

ASSOCIATES: Bunch, WH Vanderby, R

SPINAL FUSION, MATHEMATICAL MODEL, LOAD BEARING PROPERTIES

Objectives: The overall objective of this project is to investigate the biomechanics of fusion in the lumbar and thoracic regions of the human spine and its mechanical effect on adjacent free motion segments.

Methods: The methodology to achieve the goals of this study include: (i) Experimental studies to obtain data describing the geometry and load bearing properties of the spinal segments. (ii) Development of a mathematical model to adequately simulate the in-vivo response of the human spine to physiologic loads, and (iii) A parametric study, using the above mathematically model, to elucidate the effects of various fusion parameters on the biomechanics of the adjacent spinal segments.

Preliminary Results: To obtain data describing the load deformation properties of lumbar and thoracic spine segments under axial compressive loads and moments, the contact area, pressure distribution and load transmitted across the facet joints of fresh human cadaver spines were quantified using Fuji Prescale pressure-sensitive film. Also the three-dimensional geometry of the articulating facet surfaces is being studied using a 3-D digitizer. The pattern of the facet angles gives significant insight into the motion coupling behavior as a function of vertebral level.

A finite element model of the spine has been developed which incorporates an interactive optimization procedure to identify segmental stiffness properties such that the model's displacement response matches that of the in-vivo spine. This response data is taken from pre- and post-corrective x-rays, and the loading imparted by the corrective instrumentation is known. This model is being further refined to facilitate its use in conducting the parametric study mentioned earlier.

F.Y'83	F.Y'84	F.Y'85
$129,849	$138,893	$150,092

Personal Service dollars funded in support of this study is as follows

F.Y'83 $60,860
F.Y'84 $30,495
F.Y'85 $57,870

PATIENT EVALUATION OF A FUNCTIONAL ELECTRICAL STIMULATION HAND ORTHOSIS
PECKHAM, P. HUNTER, Ph.D. 541 CLEVELAND, OH
PROJECT 1
LAST REPORT, PROGRESS 07/85

ASSOCIATES: Marsolais, EB

FUNCTIONAL ELECTRICAL STIMULATION, SPINAL CORD INJURY, HAND

OBJECTIVE: The objective of this work is to develop and evaluate clinically orthotic systems employing functional electrical stimulation to provide controlled hand motion in C5 and C6 quadriplegic patients.

PLAN: Functional electrical stimulation hardware has been developed to provide two grasps. The first is palmar prehension and release provided by electrical excitation of the finger flexor and extensor muscles; the second is lateral prehension and release provided by electrical excitation of the finger flexor, thumb adductor, and thumb extensor muscles.

METHOD: A laboratory-based multichannel stimulation system has been developed to enable the investigator to determine the stimulus input - force output characteristics of each muscle, and to coordinate the level of activity of each muscle together into a coordinated movement. Up to nine separate muscles can be activated individually. The appropriate stimulus algorithms are then programmed into a patient-based unit which the subject uses functionally on an outpatient basis.

FINDINGS: Techniques for enhancing the performance of the functional electrical stimulation systems have been developed in the past year. These techniques include further refinement of the input - output (force and position) characteristics of the coordinated hand function by compensation for the nonlinear recruitment properties of electrically stimulated muscles and enhancement of command control schemes. Emphasis has been placed on enhancing reliability of the portable stimulation system. Redesign of all interconnecting cabling, connectors, and transducers, completed in the previous year, has substantially improved reliability.

CLINICAL RELATIONSHIP: Eight quadriplegic subjects are now daily users of the portable system. These subjects are using the devices for activities of daily living, including eating, grooming, and other tasks requiring manipulation skills.

F/'83	F/'84	F/'85
$183,698	$130,973	$456,355

The amount of personnel service dollars provided in support of this study is as follows:

F/'83 $122,542
F/'84 $100,424
F/'85 $230,114

RR&D#318 Altered Collagen and Wound Metabolism in Non-Healing Diabetic Ulcers
PECORARO, ROGER, M.D. 663 SEATTLE, WA
PROJECT 3
LAST REPORT, INITIAL 10/84

ASSOCIATES: Olerud, J Riederer-Henders Burgess, E
Matsen, FA Wyss, C

DIABETIC ULCERS, WOUND HEALING, DIABETES

OBJECTIVES: The purpose of this project is to identify potentially correctable metabolic abnormalities which may interact with ischemia, neuropathy, and infection to obstruct healing of diabetic ulcers.

RESEARCH PLAN: We will test whether recent poor glycemic control, abnormal ascorbic acid metabolism, altered zinc availability to injured tissue, and increased nonenzymatic glycosylation of dermal collagen are associated with and potentially responsible for failure of wound healing which leads to limb amputation in diabetic individuals. We will study diabetic and nondiabetic patients admitted to the Seattle VA Medical Center Amputation Service who require lower extremity amputation as a result of diabetes and/or vascular disease.

METHODOLOGY: 1. Glycemic control in diabetic patients will be documented by measurements of fasting plasma glucose and glycosylated hemoglobin. 2. Skin and wound tissue specimens from amputated limbs will be extracted for collagen and the extent of nonenzymatic glycosylation of collagen fractions will be measured by the thiobarbituric acid chemical assay and affinity chromatography. 3. Ascorbic acid levels in samples of plasma, leukocytes and tissue will be measured by HPLC. 4. Zinc levels will be measured in samples of plasma, leukocyte, and wound tissue by atomic absorption spectrophotometry. 5. Experimental iatrogenic microwounds will be inflicted on the limbs of volunteers seven days prior to amputation to derive a semi-quantitative independent index of cutaneous wound healing in a subset of amputation patients. This index will be correlated versus the metabolic parameters. 6. Vascular status of amputation subjects will be documented by measurements of limb transcutaneous oxygen tension (T[sub-c]PO[sub2]), laser Doppler velocimetry and segmental Doppler blood pressures. 7. Nutritional status will be evaluated by a panel of laboratory nutritional indicators which has been applied to a variety of clinical populations.

	Total Funding	Personal Services
83	$ -0-	$ -0-
84	-0-	-0-
85	$ 68,598	$30,666

SEATING SYSTEMS FOR BODY SUPPORT AND PREVENTION OF TISSUE TRAUMA
PERKASH, INDER, M.D. (51) 640 PALO ALTO, CA
PROJECT 2
LAST REPORT, PROGRESS 08/84

ASSOCIATES: O'Neill, H LeBlanc, MA

The purpose of this project is to investigate the factors which influence the development of pressure sores and postural deformities in the seated spinal cord injured individual and to develop seating system components which help to reduce the incidence of such problems. A universal contoured foam wheelchair cushion (VASIO-PARA) has been developed and clinically evaluated with 81 subjects. The cushion was found to be successful in reducing the pressure applied to the tissues of the buttocks to levels well tolerated by 79% of the subjects. The cushion was transfered to commercial production after incorporating design improvements based upon the findings from the clinical study.

Present efforts on the project are directed toward developing a better understanding of the interrelationships between cushion materials, design geometry and subject's body build and the resulting pressure distribution over the sitting surface. Investigations are also being condudcted on how variations in sitting posture alter the pressure distribution and pelvic orientation. To date, over 200 patients have been tested on the commercial version of the cushion and several design variations.

Inserts of a firmer foam are imbedded in the cushion beneath the trochanters in order to increase weight bearing in this area and decrease the load applied to the ischial tuberosities. The importance of the spacing between the insertes was investigated by comparing subjects ont two cushions, one with a 7 inch spacing and one with 8 inches. The mean ischial pressure (mean+/- standard deviation) on the right side was 85+/-27 mmHg for the 7 inch cushion and 66+/-16 mmHg for the 8 inch. Similar results were seen beneath the left ischium while no significant change was recorded at the trochanters. The manufacturer has been informed of these findings.

Preliminary work has been initiated to investigate the response of skin blood flow under conditions of applied mechanical loading. A laser doppler capillary perfusion monitor is being used to non-invasively monitor the skin blood flow. This may lead to criteria for identifying patients at risk for decubitus ulceration.

	Personal Serv
F.Y.'83 - $136,690	44,000
F.Y.'84 - $86,310	$2731
F.Y.'85 - $24,989	$19,864

Sensory Nerve Stimulation for Improved Neuromuscular Control

PETAJAN, JACK H., M.D., Ph.D. 660 SALT LAKE CITY, UT
PROJECT 3
LAST REPORT, PROGRESS 01/85

SENSORY NERVE STIMULATION, SPASTIC PARAPARESIS, FLEXOR REFLEX AFFERENTS, FUNCTIONAL ELECTRICAL STIMULATION

The influence of sural nerve stimulation (SNS) upon single motor unit (SMU) control and force of tibialis anterior (TA) muscle contraction has been determined in 17 young adult subjects. SNS was provided by a 20 Hz-0.1 square wave pulse at an intensity just sufficient to produce tingling paresthesias but no reflex withdrawal response. Subjects were requested to maintain steady firing of SMU's in TA and a constant force of foot dorsiflexion measured by strain gauge. Audiovisual feedback of SMU potentials was used to establish control. After 1 minute of stable SMU activity feedback was discontinued. 16/17 subjects were able to maintain stable firing for an additional minute, following which SNS was applied. SNS resulted in increased recruitment and a gross increase in the force of dorsiflexion in 15/17 subjects. 2/17 subjects interrupted effort. Responses were repeatable. All subjects reported feeling decreased awareness of their level of effort, and most reported a sensation of increased resistance to dorsiflexion. SNS decreased the force of maximal isometric dorsiflexion when applied during contraction.

Experiments were conducted on 6 multiple sclerosis (MS) patients with spastic paraparesis, 2 patients with hemiparesis resulting from cerebrovascular thrombosis (stroke), and 1 patient with post-anoxic dystonia. 3/6 MS patients with residual ability to dorsiflex the foot behaved similarly to control subjects. Ataxia and complete paralysis prevented adequate response in the remaining subjects. SNS applied during walking in 3 ambulatory MS patients, 2 patients with stroke and 1 patient with dystonia resulted in improved dorsiflexion and gait. Electrical stimulation of flexor reflex afferents reduces extensor tonus, enhances voluntary flexion and improves gait in patients with spastic paresis.

	Total Funding	Research Service
83 -	-0-	-0-
84 -	$33,259	$25,554
85 -	$26,500	$21,200

Role of Attention in Motor Mechanisms
PETAJAN, JACK H., M.D., Ph.D. 660 SALT LAKE CITY, UT
PROJECT 1
LAST REPORT, PROGRESS 06/85

F-wave, recruitment, motor unit, motor neuron, motor control, physiological tremor, amyotrophic lateral scelerosis, firing rate of motor units.

Research activities have focused upon objective measures of motor neuron (MN) excitability and single motor unit (SMU) recruitment. In 17 normal subjects and 13 with neurogenic atrophy (NA) the peroneal F-wave was recorded from extensor digitorum brevis, the variability of latency and wave form was examined. A dominant wave form and latency was found to be more common in patients with peripheral motor neuropathy than in controls. Reduced numbers of motor units (MUs) resulting from MN disease or neuropathy often resulted in a significant reduction in the number of different F-waves even when mean latency was normal or slightly increased.

A simple method for quantifying MU number and firing rate during a standardized level of muscle contraction has been developed. Disorders of the MU as well as movement disorders result in both qualitative and quantitative alterations in levels of innervation. The method is based upon the observation that when an extremity is against gravity SMUs are activated at a firing rate equal to physiological tremor frequency 10-13 Hz. The numbers of MUs activated is dependent only upon the muscle force required to assume a specific posture. The MN pool may be organized primarily around a system of activation designed to produce various limb positions. Thus, the elbow flexed at 45 degrees against gravity, might utilize a nearly constant proportion of MNs. This proportion might constitute a property of the normal system of motor control. Using a needle electrode, motor unit action potentials (MUAP's) were recorded from biceps brachii and triceps muscle in normal subjects and those with ALS. Muscles were activated during 45 degrees flexion or extension against gravity. The electrode was positioned to record the maximum number of different MUs. For normal subjects, 3.2 (+or-) 1.2 (n=65) and 2.9 (+or-) 1.2 (n=30) different SMUs were present in biceps and triceps respectively. Firing rates were 10.6 (+or-) 4.4 and 10.9 (+or-) 6.2 Hz respectively. For ALS patients, 2.0 (+or-) 1.1 and 1.7 (+or-) 0.9 different SMUs were found in biceps and triceps respectively. Firing rates for individual units were significantly higher in ALS (13.2 (+or-) 6.7 and 16.3 (+or-) 9.4 Hz) while total spikes per second were no different from normal. Applying these tests to patients with progressive muscular dystrophy yielded greater than six different MUs per muscle and too many action potentials for accurate counting. The method standardizes the characterization of recruitment and is sensitive to changes in MU number as well as loss of muscle fibers.

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QUANTITATIVE ANALYSIS OF THE EFFECT OF TOTAL HIP ARTHROPLASTY ON STRESS AND STRAIN IN THE HUMAN PELVIS

PETTY, ROY W., M.D. 573 GAINESVILLE, FL

PROJECT 1
LAST REPORT, PROGRESS 07/85

ASSOCIATES: Miller, GJ

TOTAL HIP ARTHROPLASTY ACETABULAR COMPONENTS BIOMECHANICS

OBJECTIVE OF THE PROJECT: The above project is intended to quantiatively evaluate the effects of differing acetabular implant designs and implantation techniques on the stresses and strains developed in the human pelvis.

RESEARCH PLAN: The plan includes the comparison of the right to left variability in the strains in the hemipelvis using the normal femoral head, Austin-Moore prosthesis, and the effect of acetabular cup replacement and techniques. These techniques include differing methods of acetabulum preparation, cement introduction, and varying cup designs. Cup designs include metal backing, fiber reinforcement, surface mounted spacers to insure uniform cement mantel, incorporated spacers, and various other compositions.

FINDINGS AND RESULTS OR CONCLUSIONS: Our results indicate that violation of the subchondrial bone increases pelvic principle strain magnitudes. Pilot hole sizing configuration can have a marked effect on increasing pelvic strain which can be detrimental to the implantation. The use of an Austin-Moore or other well fitting hemiarhtroplasty in the unaltered acetabulum is comparable to the loaded normal femoral head. The use of differing key-hole configurations to enhance cementation can have a marked effect on the strain in the pelvis usually resulting in increased strains. Most recently, the use of Cobalt Chrome metal backed components have been shown to unload the hemipelvis so that strain values are decreased when compared to more conventional polyethylene components. The use the Titanium metal backed prosthesis tends to result in only small strain changes, usually a slight increase, which would seem to be preferable for long term success of the arthroplasty. These most recently obtained results match well with other published computer simulations and appear to verify the modeling technique being used.

FY'83	FY'84	FY'85
$35,526	$49,250	$46,483

The amount of personal service dollars provided in support of this study is as follows:

FY83	$23,440
FY84	$36,396
FY85	$38,605

Assessment of the Spatial and Temporal Characteristics of Vision as a Function of Age

RINALDUCCI, EDWARD J., Ph.D. 508 DECATUR, GA
PROJECT 1
LAST REPORT, INITIAL 06/85

vision, aging, spatial contrast, visual persistence, assessment

The main objective of the proposed research is to examine changes that occur in the spatial and temporal properties of the human visual system as a function of the aging process. It is proposed that data of a preliminary nature be gathered on spatial contrast sensitivity and visual persistence for a group of young adults observers(18-29 years), middle-aged(30-49 years) and older observers (50-75 years).

The spatial contrast sensitivity function is essentially a spatial modulation transfer function (MTF) of the visual system. It is based on Fourier's Theorem which implies that it is possible to take any light pattern and analyze it as a set of sine waves (spatial frequencies) much the same way as sound has been analyzed as combinations of simple tonal sine waves. To assess the visual system's limitations in resolving changes in light intensity over space, one can measure the observer's threshold for detecting sine wave gratings as different from uniform stimuli for a range of spatial frequencies (i.e., spatial sine wave gratings varying in the number of cycles per degrees of visual angle). The spatial contrast sensitivity function (CSF) provides a basis for predicting the apparent brightness of many types of stimulus configurations. The CSF has a characteristic shape for the normal young adult visual system and should vary in level or shape as a function of age and/or pathology.

The temporal characteristics of the human visual refer to how it responds to changes in the perceived duration of the visual stimulus (e.g, a spatial sine wave grating). The temporal response characteristics of the visual system can be examined through the phenomenon of visual persistence. Visual persistence refers to the existence of an internal representation of a briefly presented stimulus which remains available (i.e., persists) to the subject after the offset of the stimulus.

A Vistech Vision Contrast Test will be used to obtain a rapid assessment of spatial contrast sensitivity for each subject. An estimate of visual persistence will be obtained using a microcomputer controlled CRT system in conjunction with the eye and ear method in which sujbects are required to match the offset of a visual stimulus (i.e., a sine wave grating) with the onset of an auditory stimulus. The visual stimuli will be viewed through an optical system which controls for any changes in pupil size due to adaptation or age (i.e., a Maxwellian-view optical system).

The obtained results should provide information for programmatic research to establish techniques for visual assessment in the aged. This research should help provide a detailed description of the rates at which different visual functions change with age, identify possible individual differences in these changes, specify conditions which may limit visual .

	Total Funding	Recurring Basis
83-	-0-	-0-
84	-0-	-0-
85	$5,000	-0-

functioning in the older person, and suggests proper directions for the design of sensory aids.

Predictive Factors for Restrengthening Paralyzed Muscle by Electrical Stimulation
ROBINSON, CHARLES J., DSC 578 HINES, IL
PROJECT 4
LAST REPORT, PROGRESS 06/85

Spinal Cord Injury, Functional Electrical Stimulation

Electrical stimulation of paralyzed muscle could be potentially useful for many persons with spinal cord injuries, however little work has been done to document this assumption. Furthermore, electrical stimulation is not presently being used on a large scale for persons with spinal cord injuries, because physicians cannot predict how various patients will respond to electrical stimulation. The goal of this project is to develop a set of tests that will help physicians to predict the responses of muscles to electrical stimulation.

We have begun preliminary studies on determining predictive factors with 18 patients of the Hines VA Spinal Cord Injury Service. All patients have given their informed consent to the research protocol. This predominantly male population provides a diverse mix in terms of level and completeness of injury, actual age and years post injury, height and weight, and medical and psychological complications brought on as a result of spinal injury.

We have considered individuals with damage to their spinal cord below T11, with severe peripheral vascular or cardiovascular problems or with pressure sores in areas affected by stimulation, for this protocol.

We completed initial evaluations on the 18 current participants, using electromyographic radiographic (CT scan), and neuromuscular techniques, before entering them in a 4 to 8 week protocol. In this protocol we are stimulating their thigh muscles twice daily during 20-minute exercise sessions, tracking changes in thigh muscle force and fatigue characteristics from week to week. Preliminary results suggest a possible correlation between residual muscle mass (as determined by CT scan) and initial response to electrical stimulation.

[illegible] Trend [illegible]
$ -0- $ .0-

Electrical Stimulation of Paralyzed Muscle After Spinal Injury
ROBINSON, CHARLES J., DSC 578 HINES, IL
PROJECT 3
LAST REPORT, PROGRESS 06/85

Spinal Cord Injury, Functional Electrical Stimulation
Individuals with spinal cord injury have absent or diminished control over muscles that are innvervated below the level of their injury. Many of these paralyzed muscles can be activated by electrical stimulation of the nerves leading these muscles.
This study attempts to identify the therapeutic benefits of a regular program of electrically induced leg reconditioning and exercise in a general population of veterans whose legs have been paralyzed by spinal cord injury. The study group consists of individuals with paraplegia and quadriplegia who are patients of the Spinal Cord Injury Service of the Veterans Administration Hospital at Hines, IL. This predominantly male population provides a diverse mix in terms of level and completeness of injury; actual age and years post injury; height and weight; and the extent of cardiovascular, renal, urinary, skeletal, neuromuscular, peripheral vascular, cutaneous and psychological complications brought on as a result of spinal injury. We did not consider individuals with damage to their spinal cord below T11, with severe peripheral vascular or cardiovascular problems, or with pressure sores in areas affected by stimulation, for this protocol. To date, we have completed baseline evaluations on 21 qualifying individuals. We screen an average of 3 or 4 additional potential candidates each month. For the most part, the qualifying individuals had incomplete quadriplegia (n=10) or complete paraplegia at T11 or above (n=7).
For this study we first measured torque and fatigue characteristics produced by an 100 ma stimulus (a 20 hz train of 0.5 msec compensated monophasic pulses) delivered to the knee extensors via large (2x4cm) water-soaked surface electrodes in alternating fashion (2.5 sec ON, 2.5 sec OFF). We then placed 18 individuals in a twice-daily 6-day-a-week, 20-minute exercise protocol, with weekly assessment of progress. After 4 to 8 weeks of electrically induced exercise, some participants exhibited large increases in muscle force and fatigue-resistance, while others showed little change. We are now attempting to correlate the extent of increases seen (if any) with our observations.

	Total Funding	Personnel Services
83	$ -0-	$ -0-
84	$ -0-	$ -0-
85	$ 12,500	$ -0-

Neural Mechanisms Underlying Bladder Dysfunction After Spinal Trauma

ROBINSON, CHARLES J., DSC 578 HINES, IL
PROJECT 2
LAST REPORT, PROGRESS 06/85

Spinal Cord Injury, Functional Electrical Stimulation

Renal complications are the primary cause of death during the long-term management of persons with spinal cord injuries. These complications are a direct result of the bladder dysfunction that almost always accompanies spinal cord injury. This project's goal is to learn more about the underlying mechanisms of bladder dysfunction following spinal trauma and to use this knowledge to develop ways to enhance the recovery of bladder function after spinal trauma. It compliments our other studies, which focus on ways to overcome paralysis in humans.

We have two objectives for this project: 1) develop an animal model to study micturition dysfunction after spinal trauma and, 2) use this model to study the effects of various drugs on the spinal control of micturition. We chronically measure the relationship between bladder volume and pressure before and after the spinal administration of opiate agonists and antagonists, and before and after spinal trauma, using pairs of ultrasonic crystals that have been implanted in the bladder wall and a miniature pressure transducer implanted into the bladder.

Our research lead to a better understanding of a the neurophysiology and neuropharmacology of bladder function, because we can measure and manipulate many of the neural and muscular events underlying bladder function in the unanesthetized animal. Such understanding is needed because renal complications remain the number one cause of death during the long term management of the spinal core injured patient. These complications are a direct result of the bladder dysfunction that almost always accompanies spinal cord injury.

F.Y '83	F.Y '84	F.Y '85
$22,163	$47,678	$12,506

Personnel Service dollars provided in support of this study is as follows

F.Y 83 $20,314
F.Y 84 $28,795
F.Y 85 $1,175

Residual Bladder Volume Determination for Spinal Cord Injury Patients
ROEMER, ROBERT, Ph.D. 678 TUCSON, AZ
PROJECT 1
LAST REPORT, PROGRESS 08/85

ASSOCIATES: Drach, G Mylrae, K

SPINAL CORD INJURY, BLADDER VOLUME, PROSTATE

During the past year we have: (1) completed our laboratory testing with our prototype system & (2) used those results to modify & simplify our data sampling process, & the develop a post processing algorithm for improved accuracy. The simpler, improved approach has given an average accuracy of better than 8% with a standard deviation of 5% for fifteen subjects with volumes between 50 & 300 cc. Further post processing improvements are now being incorporated. (3) The final design of all components for the clinical prototype system have been completed, all individual components have been checked, & the prototype system is being put together for interface checks & clinical tests in Fall 1986.

	Total Funding	Personnel Serv
#	83 - \$48,086	\$1,586
	84 - 35,571	-0-
	85 - 39,008	-0-

Computerized Treatment of Acquired Reading Disorders
ROTHI, L.J. GONZALEZ, Ph.D. 573 GAINESVILLE, FL
PROJECT 1
LAST REPORT, PROGRESS 06/85

LEXICAL, PHONOLOGICAL
OBJECTIVE OF THE PROJECT
1. To develop therapy tasks suitable to improve deficient reading strategies associated with the lexical route or the phonological route.
2. To develop computer programs for an intractive computer which would provide the patient with self-paced practice on the above tasks.
3. To assess the efficacy of these treatment tasks when presented via computer interaction.
RESEARCH PLAN AND METHODOLOGY
Each patient will receive standardize pre-and post-therapy testing plus patient progress on each of the six tasks of therapy will be monitored daily.
Twelve subjects will be tested; 6 with deep dyslexia and 6 with surface dyslexia. Six tasks will be presented to each patient in each subject group (three directed at remediating the lexical route and three for the phonological route) during a total of 26 sessions. The tasks will be presented via IBM PC/XT and patient's responses will be scored, analyzed and stored on the computer.
FINDINGS, RESULTS OR CONCLUSIONS REACHED TO DATE
No subjects have been tested thus far therefore we have no findings, results or conclusions available.

	Total Funding	Personal Services
83	$ -0-	-0-
84	$ -0-	-0-
85	$6610	$5550

Changes in Frequency Organization of the Cochlea During Aging

RYALS, BRENDA M., Ph.D. 652 RICHMOND, VA
PROJECT 258
LAST REPORT, INITIAL 11/84

ASSOCIATES: Rubel, EW

FREQUENCY ORGANIZATION OF THE COCHLEA, AGED AUDITORY END ORGAN, ACOUSTIC OVERSTIMULATION

PROJECT OBJECTIVES: (1) To determine the effects of age of acoustic overstimulation on the frequency of maximum AP threshold shift, (2) To correlate these findings with anatomical results, (3) To analyze position of maximum hair cell loss and the frequency of maximum VIII nerve threshold elevation after pure tone acoustic overstimulation in the aged auditory end organ.

RESEARCH PLAN: In the first set of experiments VIII nerve compound action potential thresholds are measured after acoustic overstimulation in chicks exposed to an intense pure tone stimulation at various ages in early life. After physiologic data is obtained, anatomical analysis of the basilar papilla is performed at the light microscope level. In the second set of experiments normal VIII nerve AP thresholds are determined throughout the entire lifespan of Japanese Quail. Variations in thresholds are then determined throughout lifespan as a function of age of acoustic trauma. Anatomical correlations are made at the hair cell level of all age groups.

METHODS: Compound VIII nerve action potentials are recorded using signal averaging techniques. Anatomical analysis is performed on plastic embedded tissue which has been sectioned in semi-thin sections using an ultramicrotome. Sections are analyzed at the light microscope level.

CLINICAL RELATIONSHIP: This area of research has far reaching implications for the prevention and/or rehabilitation of hearing loss in old age.

	Total Funding	Personal Services
	$	$
83	-0-	-0-
84	-0-	-0-
85	$ 98,599	$ 35,800

DEVELOPMENT OF HINDFOOT JOINT RESURFACING PROSTHESES
SAMUELSON, KENT M., M.D. 660 SALT LAKE CITY, UT
PROJECT 1
LAST REPORT, FINAL 09/83

ASSOCIATES: Daniels, AU

TALUS, NAVICULAR, CALCANEUS, JOINT, PROSTHESIS

The human hindfoot joints often become chronically deformed by disease and traumatic injury. Conventional treatment for related pain and loss of function is arthrodesis, and severe injury of the talus may require talectomy. Prosthetic talonavicular resurfacing has worked well initially. Where additional talar joints are involved, resurfacing would require excessive bone removal, risking talar necrosis. Conversely, arthrodesis results in abnormal force distribution in surrounding joints, and talectomy results in a shortened leg and deformed foot.

This work was undertaken to develop hindfoot joint replacement further, based on initial success with the talonavicular joint. First it was shown that the surface geometry of the existing talonavicular prosthesis corresponded closely to the natural adult joint. Next, a fiber optic force transducer was incorporated into the talar prosthetic component. In tibially loaded cadaver specimens, maximum force occurred at extreme plantar flexion & intermediate varus. Force was proportional to the tibial load. Cancellous talonavicular bone strength was found adequate to support the base areas of the prosthetic components under anticipated loads. In related work, embalming increased shear and compressive strength of cancellous bone significantly.

Finally, a prototype total talar replacement component was developed. The complex surface of the subtalar joint was replaced by a carefully oriented cylindrical surface. Other articular surfaces were designed to interface with existing tibial (ankle) and navicular prosthetic components. In cadaver implantations motion of the joint was essentially normal. The components is unique in joint replacement in that it includes three functionally separate joint surfaces.

	TOTAL	Revenue Svcs
FY'83	$56,400	$ N/A
FY'84	-0-	-0-
FY'85	-0-	-0-

The Role of Pressure Distribution Measurement in Diabetic Foot Care

SANDERS, LEE J., DPM 595 LEBANON, PA
PROJECT 2
LAST REPORT, INITIAL 05/85

ASSOCIATES: Cavanagh, PR

Diabetic foot, Neurotrophjic ulcers, pressure distribution, pressure measurement

The medical complications of diabetes mellitus are often so overwhelming for the patient that they tend to dominate the early treatment of the disease. Frequently it is not until many years later, when the vascular and neurological complications of diabetes have robbed the foot of its normal sensation, that the orthopedic and podiatric problems of the foot receive attention. This delay could be critical to the patient since the diabetic foot is prone to the development of lesions secondary to vascular disease and peripheral neuropathy. These lesions provide a prime focus for infection with resultant gangrene and amputation. The majority of thes lesions are usually on the plantar aspect of the foot and recent studies have established quite unequivocally that excess pressure is present at the site of the lesion. Since this relationship has been well established, it is time to ask a new set of questions that may lead to the prevention of lesions. Specifically, if regions of high pressure can be identified, will a program of enhanced foot care prevent the development of lesions in this patient's feet.

In order to investigate this problem, an initial objective of the proposed research is to develop a system for on-line collection, processing and display of pressure distribution data. In addition, we will ateempt to determine the value of enhanced podiatric care that includes aggressive prevention and early management. A subjective comparison between pressure measurement data and medical screening results will be made for each subject.

A group of diabetic patients will be selected on the basis of the duration of their disease, positive findings of peripheral neuropathy and vasculopathy, and the absence of lesions on their feet. These patients will be divided into two treatment groups, a "normal care" group and an "enhanced care" group which will receive more frequent and more intensive clinical care. A control group of age and weight matched subjects will also be studied.

Total Funding - Personnel Services

See Sanders other project

Measurement of Pressure Distribution Under the Feet of Diabetics
SANDERS, LEE J., DPM 595 LEBANON, PA
PROJECT 1
LAST REPORT, FINAL 05/85

ASSOCIATES: Cavanagh, PR

Diabetes, Pressure Measurements, Neuropathic Ulcers, Feet
This pilot study was a joint project between the Podiatry Section at the Lebanon VA Medical Center and the Biomechanics Laboratory of the Pennsylvania State University. The objective of this research was to follow a selected group of diabetic patients over a 12 month period to determine whether pressure distribution measurement has any predictive value in determining those patients who will eventually develop neuropathic ulcers on the plantar surface of the foot.
A total of 53 patients had been evaluated. A thorough lower extremity physical examination was conducted, including sensory testing, vascular exam with doppler evaluation, detailed podiatric exam, assessment of the medical history, and analysis of foot x-rays. Subsequent to the medical screening, the subjects footprints and Harris mat prints were taken and then three trials of pressure distribution measurement from each foot were collected from our 1000 element piezoelectric pressure distribution platform.
Our results to date have emphasized the labile nature of the diabetic population. In this time period there were three deaths, four amputations at various levels, four other surgical interventions and 9 infected pedal ulcers. Photographs of the computer generated graphics, summarizing the pressure distribution data, were provided for each patient and compared with the clinical data. Regions of high pressure were seen to correlate with the presence of neurotrophic ulcers. Empirically, pressure distribution measurements have predictive value in determining "at-risk" areas on the weight bearing surface of the diabetic foot.

	Total Funding	Personnel Services
F/83	-0-	-0-
F/84	$4,000	$ —
F/85	$133,836	$27,378

Assistive Powered Devices for the High Spinal Cord Injured Person
SCHMEISSER, GERHARD, M.D. 512 BALTIMORE, MD
PROJECT 1
LAST REPORT, INITIAL 07/83

ASSOCIATES: Seamone, W Schneider, W Loveless, J

PROJECT OBJECTIVES: To enhance the potential of a prototype high technology assistive device system, to enable high level quadriplegics to perform a wider range of useful tasks independently and thereby to improve the quality of their lives.

PLAN AND METHOD: To deploy an advanced prototype of the system including a motorized wheelchair, chin-controller, robotic arm, and worktable to each of two VA Spinal Cord Injury Centers (Richmond, Virginia & Cleveland, Ohio) for specific periods of clinical evaluation & development using quadriplegic veteran volunteers in each of these Centers under the supervision of an appropriately trained person assigned by the Chief of Service. Periodically the equipment is to be withdrawn from the VA Medical Center to the Johns Hopkins University Applied Physics Laboratory for refurbishments to address new needs identified at the Spinal Cord Injury Center. Two months of refurbishment and design changes will be scheduled at the JHU/APL at the end of each 4-6 months of clinical evaluation. Periods of clinical evaluation following the periods of refurbishment will enable check-out of modifications.

FY'83	FY'84	FY'85
$143,000	$157,000	$182,800

Salary provided in FY'83 amounted to $60,039, and no salary dollars were provided in FY'84. For FY'85, $11,800 was provided in salary dollars

MICROSURGICAL TECHNIQUES APPLIED TO ORTHOPAEDIC AND HAND SURGERY

SHAFFER, JOHN W., M.D. 541 CLEVELAND, OH
PROJECT 1
LAST REPORT, PROGRESS 09/85

MICROSURGERY, VASCULARIZED BONE GRAFTS, BONE SCANS
OBJECTIVE: To monitor vascularized bone grafts the post-operative bone scan has been felt to be satisfactory. 24 one week canine vascularized ulna autograft experiments were done where 15 technecium 99m methylene diphosphonate bone scans were done one week after surgery.
METHODS: In each forelimb ulna studied a 4 centimeter vascualarized ulna autograft was placed on one side while a non-vascularized ulna autograft was done on the other. The vascular pedicle was cut and re-anastomosis was done using 10-0 nylon suture, micro-instruments, and the operating microscope. On the contralateral nonvascular side 4 centimeters of ulna were mobilized and stripped free of all soft tissues. Each dog was given fluorochrome markers at intervals post-op to permit serial analysis of bone repair. Fifteen dogs were studied one week post-op with a technecium 99m methylene diphosphonate bone scan for non-invasive information about the graft metabolic state and perfusion. Imaging was done 2 to 4 hours after injection of the bone seeking markers. At autopsy the forelimbs were perfused with BaS04 prussian blue mixture. Frozen bone 100 micron thick transverse sections were obtained for fluorochrome analysis and micro-angiogram.
RESULTS: Animals ambulated the day after surgery. There were 12 of 15 positive bone scans vascularized ulna grafts. However, there were 11 of 15 positive bone scans in the control non-vascularized ulna autografts. Positive micro-angiograms demonstrated dye within arterial vessels of the periosteium, cortex and medullary canal while negative micro-angiogram demonstrated complete absence of dye. Therefore, blood flow did not distinguish the groups to account for 11 of 15 false positive bone scans in the non-vascularized ulna grafts. However, the fluorescence pattern was similar in both the vascularized and non-vascularized ulna grafts with repair in progress.
SUMMARY: A positive bone scan in this model correlated with early bone repair in both vascularized and non-vascularized ulna autografts. A positive bone scan did not correlate with the perfusion of the vascualarized & non-vascualarized grafts as measured by the micro-angiograms. A negative bone scan correlated with the absence of bone repair in both the vascularized and non-vascularized ulna autografts.

FY'83	FY'84	FY'85
$77,087	$58,986	-0-

Funding provided for personnel services in support of this study is as follows:
FY'83 $14,940
FY'84 $6,924

Determination of Causes and Mechanisms of Chronic Phantom Limb Pain

SHERMAN, RICHARD A., Ph.D. 509 AUGUSTA, GA
PROJECT 1
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Barja, RH Ernst, J Sherman, CJ

CHRONIC PAIN, PHANTOM LIMB, MECHANISMS

OBJECTIVE: To determine causes and mechanisms of chronic phantom limb pain. Many amputees may be able to predict changes in their phantom pain based on changes in external or internal factors. Changes in several recordable physiological parameters may start and/or alter the intensity of episodes of phantom pain. Demonstration of this hypothesis will permit development of effective treatments for chronic phantom limb pain.

PLAN: a) Survey 6,300 veteran amputees to determine which external and internal factors (i.e., humidity and back pain) initiate and/or alter the intensity of episodes of phantom limb pain. b) For each factor identified, have 100 of the above respondents log changes in the factor and their pain for one year to establish exact temporal and multifactoral interrelationships. c) Carry out psychophysiological evaluations of 100 amputees representing each of the major descriptirs of phantom limb pain. These amputees will be recorded twice while pain free and twice whole experiencing phantom pain.

METHODOLOGY: The physiological evaluations will consist of: a) near surface blood flow analysis of the stump and intact pair done with a videothermography system sensitive to 0.1 degree C down to 1.5 cm deep; b) blood pressure from all four limbs using an automatic sphygmomanometer; c) surface electromyographic measurement of the major stump muscles and the intact pair in various positions and against different resistances using EMG representations of tension in the 8 to 1000 Hz bandwidth; d) surface electromyographic measurements of the low back muscles while the subject is in a variety of positions demonstrated to effect the lower limbs using a bandwidth of 90 to 1000 Hz.

RESULTS TO DATE: a) Survey: a trial survey was sent the 1,300 veteran amputees to test the instrument. Results from the 50% who responded indicate that about half are aware of internal or external factors which influence their phantom pain. There was no relationship between need to control what happens and awareness of factors influencing phantom pain. A finalized version of the survey has been sent to 5,000 other veteran amputees. b) Log: sixty respondents from the trial survey have kept daily logs of physical, emotional, and climatic factors and their pain intensity for over six months. Different factors correlate highly with change in pain for different people. c) Physiological Recordings: we have completed multiple recordings of 26 veteran amputees and are working with ten others. For burning phantom pain there is an inverse correlation between intensity and amount of blood flow.

	Total Funding	Personnel Serv
83	-0-	-0-
84	$-0-	$-0-
85	65,954	26,037

Pathokinesiology of Anterior Cruciate Ligament Deficiency
SHIAVI, RICHARD G., Ph.D. 626 NASHVILLE, TN
PROJECT 5
LAST REPORT, PROGRESS 05/85

Knee kinematics; screw motion; locomotion
Objectives: To develop a normative base of functional knee mechanics, to identify the pathomechanics of the anterior cruciate deficient knee during function and to develop a rational basis for therapeutic intervention from information acquired in parts B1 and B2.
Plan: Instability of the knee joint secondary to rupture of the anterior cruciate ligament is a major problem in active individuals. Absence of the ligament leads to functional disability in the majority of patients and the eventual development of degenerative osteroarthritis. Even though multiple treatment programs have been developed, no functional evaluation of the anterior cruciate deficient knee or precise objective evaluations of the therapeutic interventions are available.
Method: Electromyograms, motions and floor reaction forces will be measured using equipment in Gait Analysis Laboratory in normal volunteers and patients during walking and pivoting. All data is stored in a computer and on magnetic tape. Moments and forces on and detailed motions of the knee joint will be calculated from the date. Electromyograms of thigh musculature and torques about the knee produced during controlled exercise will be measured using a Cybex isokinetic located in the Physical Therapy Department of Vanderbilt University.
Findings: Excellent quality data has been collected on 15 uninjured and 10 knee-injured individuals. Two types of analysis are being studied and the results will be presented in conferences this year. These are the statistics of the anatomic kinematics and screw motions of the knee and the synergy patterns of muscles about the knee.

Funding Allocation	Personal Services
F.Y'83 - 0 -	—
F.Y'84 - B - 94,298	69,768
F.Y'85 - B - 67,257	53,534

Efficacy of Radiolucent Low Modulus Total Hip Surface Replacement
SKINNER, HARRY B., M.D., Ph.D. 629 NEW ORLEANS, LA
PROJECT 1
LAST REPORT, FINAL 02/83

ASSOCIATES: Cook, SD Haddad, RJ

The objective of the proposed research is to investigate the potential using a unique radiolucent, low modulus, carbon-polyethlene (UHMWPE) surface replacement prothesis for the hip. This prothesis will consist of a pyrolytic carbon femoral component and an ultra high moleculan weight polyethylene acetabular component. The device will be tested in a canine model. In addition, a comparable human prothesis will be developed and studied in a cadaver model to determine the diagnostic benefits of radiolucent material components. The feasibility of this hip prosthesis implant system will be evaluated by implantation in a canine model using both unilater and bilateral conditions. Force plate gait analysis of the dogs and histological sections of the interface between the prosthetic components and bone will be the primary evaluation techniques. Histological studies of coronal sections will be used to provide specimens for evaluation of trabecular bone response by quantitative stereology techniques. In conjunction with the animal studies, it is planned to use human skeleton pelves and femurs to demonstrate radiographically how the femoral head can be examined through the carbon cup by means of different roentgenographic views of the hip. Prosthesis design will be modified to permit maximal visualization. This should be of great benefit in the diagnosis of hip pain after surface replacement, thereby reducing the risk of catastrophic failure and reducing the health cost by allowing early diagnosis and non-surgical medical treatment or conservative surgical treatment.

Principal Investigator has transferred to VAMC, San Francisco, CA.

Funding allocation	Personal services
F-1'83 - $ 76.293	$ 44.387
F-1'84 - $ 60,902	$ 14.192
F-1'85 - $ 96,436	$ 74.098

The Efficacy of Radiolucent Low Modulus Total Hip Surface Replacement

SKINNER, HARRY B., M.D., Ph.D. 662 SAN FRANCISCO, CA
PROJECT 1
LAST REPORT, PROGRESS 09/85

ASSOCIATES: Cook, SD

Hip Surface Replacement, Bone Remodeling

The purpose of this project is to investigate the potential of using a radiolucent low-modulus surface replacement as a prosthesis for the hip. This study is a bone remodeling study in that a comparison of the canellous bone under a carbon femoral surface replacement is to be compared to the normal cancellous bone in the contralateral hip. In addition the bone under a carbon femoral prosthesis is to be compared directly to the cancellous bone of the contralateral femoral head which has been resurfaced with a cobalt chromium prosthesis of a much higher modulus.

At this point all of the unilateral carbon replacements have been retrieved and are undergoing quantitative trabecular stereology. All of the bilateral replacements have been implanted and will have been retrieved by January, 1986. These then will undergo histologic examination and quantitative trabecular stereology. In the mean time finite element studies of the femoral head with the carbon and with the cobalt chromium prosthesis are underway and preliminary results have been obtained which must eventually be compared to the results of the quantitative trabecular stereology.

Computerized tomographic scanning of the unilarteral normal control hips has been performed. The data obtained from these studies will also be compared to the results of the quantitative trabecular stereology for those animals with a carbon surface replacement.

In an attempt to improve the finite element studies an algorithm has been developed for use on CT scan data to define trabecular pattern so that this information may be included in finite element modeling. A present work is progressing on using CT scan data to generate finite element meshes. It is anticipated that the histologic studies will be completed early in 1986.

Development, Testing and Evaluation of Prosthetic Devices/Training of Prosthetists
SKINNER, HARRY B., M.D., Ph.D. 662 SAN FRANCISCO, CA
PROJECT 2
LAST REPORT, FINAL 01/85

Prosthetic foot function Articulated prosthetic foot Training of Prosthetists Prescription standards Prosthetic research

Abstract

This is a final report for the Development, Testing and Evaluation of Prosthetic Devices program at the Veterans Administration Medical Center in San Francisco. The project has consisted of four parts including a study of the SACH foot (Solid ankle cushion heel), the Light weight three component below-knee prosthesis, the MACH foot (Moveable ankle cushion heel), and prosthetist training. Although the final goals described in various proposed programs have not been realized, significant strides have been made.

Static studies of the SACH foot have been carried out and these have been published while dynamic studies are still under way. The Light weight three component below-knee prosthesis have overcome several problems in design and is now presently seventy-five percent complete. The MACH foot development has had several design problems which have slowed progress despite the fact that clinical prototypes have been well accepted. Prosthetist training has resulted in one trainee being certified in prosthetics. Numerous publications are in print or undergoing the review process prior to publication.

Prosthetic foot function Articulated prosthetic foot Training of Prosthetists Prescription standards Prosthetic research

SACH Foot Study

The SACH foot (solid ankle cushion heel) is a frequently prescribed foot prosthesis for below-knee and above-knee prostheses. The objective of this portion of the study was to evaluate the static and dynamic characteristics of the SACH heel. Static measurements of the SACH heel have been performed. This study has demonstrated that there is little difference between the static characteristics of soft, medium and regular heels on the SACH foot. These data will be presented in the February 1985 issue of Orthopedics. The dynamic response of the SACH foot was been investigated in two amputees using data obtained on two below-knee amputees from the gait analysis laboratory in San Diego at Children's Hospital. These data have been analysed and have been used to help analyze a dynamic model of the SACH heel. This work is ongoing and will be continued despite the termination of this project.

Lightweight Three Component Below-Knee Prosthesis

The objective of this study is the development and testig of a new design for below-knee prostheses that will combine the advantages of a light weight design, prefabrication of shank and foot components, a more foolproof method of alignment, and improved foot function and gait performance.

Total Funding	Personnel Services
-0-	-0-

SKINNER, HARRY B., M.D., Ph.D. 662 SAN FRANCISCO, CA
PROJECT 2

The development stage of this project is presently 75% complete. Nine of the twelve initial masermolds for the shank portion of the prosthesis have been completed. Two others are in various stages of completion.

During this time, numerous test shanks have been laminated from the completed mastermolds. A laminate, consisting of polyester resin with fiberglass and carbon fiber reinforcing, is being used. The resultant weight of these shanks vary from 11 to 13 oz., depending on the shank size.

Master positive models of the foot component have been completed for ten of the initial twelve feet. Eight of these have been converted into master molds. Three polyurethane foams of varying free foam density have been obtained and are currently being evaluated for patient use.

Patient testing and evaluation has begun for the 3-Component Prosthesis. Four amputee research subjects have been fitted with prototype prostheses. The weights of these finished prostheses are 1.75, 2.15, 2.25, 2.5 lbs, (without shoes). Patient acceptance has been very high in terms of function, comfort, cosmesis and weight. The prosthesis has also proven to be durable with no structural failures in up to 2 1/2 years of prosthesis use.

MACH Foot Development

The MACH (moveable ankle cushion heel) foot project has progressed to a point where four prototypes have been made and are currently being used by amputee research subjects. These test feet exhibit 10 - 15(dot) of initial plantar flexion (before heel compression), 5 - 7(dot) of inversion and eversion, and 5 - 7(dot) of rotation. The weight of these have run 1/8 to 1/4 of pound less than a similar sized SACH foot.

The response from the amputees has been overwhelmingly in favor of the foot. While we are very satisfied with the function of the present design, there are problems with the fabrication procedure. Some changes in the design of the ankle joint need to be incorporated with a new method of fabrication that will be less labor intensive than the current procedure.

Prosthetist Training

The objective of providing training for prosthetists in research methodology is preceding smoothly. The initial trainee in the program has recently been certified in prosthetics. During his tenure here, he has been an active participant in the health care team concept as practiced by this medical center. He has been exposed to advance fitting and fabrication techniques as well as receiving "hands-on" experience in dealing with the problem cases that are frequently referred to this research program.

The trainee has also been heavily involved in the research projects generated within the Rehabilition Research & Development program. This includes materials research, mold and model making techniques, and application of advanced fiber reinforcing materials. He also gained valuable experience writing technical papers and reviewing articles.

Memory Remediation in Older Adults: A Computerized Interactive System
SMITH, ANDERSON DODD, Ph.D. 508 DECATUR, GA
PROJECT 1
LAST REPORT, INITIAL 06/85

ASSOCIATES: Wall, DD Rogers, CM

Memory, Memory assessment, Memory remediation, Cognition, Computers

The objective of the current project is to develop an interactive computerized memory task that allows subjects/patients to practice specific everyday memory skills, First, specific memory skills will be identified for pilot use in two ways. Memory questionnaires will be examined from normative studies in the literature. Second, skills will be identified through interviews and surveys of both VA patient/subjects and VA staff working with older adults on a daily basis. Programs will be developed using MUMPS language which are designed to train and practice the memory skills through interaction with the computer terminal. The interactive system will then be evaluated, both in terms of its validity of memory improvement and in terms of user compatibility (user response).

Memory assessment for older adults in clinical settings often involves global assessment batteries (e.g., Wechsler Memory scale), tests deriving from the psychometric perspective that often have limited applications when remediation is desired. The current project plans to use "everyday" memories, thereby addressing the specific memory problems as they are identified by either the clinician or by the older adult him- or herself.

The project team consists of a cognitive psychologist with extensive research experience with memory performance in older adults, a VA clinician with experience with geriatric medicine and the VA population, and a mathematician with expertise in computer systems design and programming. The plan is for the research team to conduct the necessary pilot work to test feasibility for the project, and then to submit a large proposal to VA at a later time.

	Total Funding	Personal Services
83	-0-	-0-
84	-0-	-0-
85	$6,000	-0-

BONE IN VIVO STRESS AND STRAIN PATTERNS: INFLUENCE OF AGE AND ACTIVITY

SPENGLER, DAN, M.D. 663 SEATTLE, WA
PROJECT 3
LAST REPORT, FINAL 07/83

ASSOCIATES: Keller, TS Carter, DR Baylink, DJ

We are presently studying the influence of age on rat bone structural material properties. An in vitro torsion testing procedure was used to elucidate the effect of animal age and weight on the structural geometric material properties of rat femora. Rats ranging in age from 21 to 200 days (40 to 500 grams) have been examined. During torsion testing selected specimens had rosette strain gauges bonded to the antierior surface of the femur at mid-diaphysis. Contralateral femurs provided mid-diaphyseal cross sections and ash weights. Total bone length (L), major (a), and minor (b) axes dimensions at mid-diaphysis were recorded. Sectional properties (area, I(sub-xx), I(sub-yy), I(sub-xy), I(sub-p)=I(sub-xx)+I(sub-yy) are determined using a computerized numerical procedure. Assuming that the femora cross-sections can be approximated by a hollow ellipse of major axis (a), minor axis (b) and thickness (t), then t can be claculated such that I(sub-p) (ellipse) = I(sub-p) (true section). Maximum shear stress is then calculated as T = T/Q, where Q (m(supra 3) is a function of a, b, and t. Shear modulus G = T/gamma is determined where gamma is a maximum shear strain obtained from the strain gauge recordings. Non-failure torsion tests agreed within 5% with the failure torsion tests. Results indicate that changes in the structural properties of the rat femur cease at approximately age 110 days. The age of 21 to 110 days of torsion strength increased 1650% and the torsional stiffness increases 1280%. The increase in structural properties was caused by both geometrical and amterial property changes in the bones. Over the age range examined the shear strength of the bone tissue increased by a factor of 3 and the shear modulus by a factor of 2. Log-Log plots of t, k, and g versus bone length and animal age or weight revealed allometric relationship (y = ax(supra b))which indicate that bone geometry and material are being regulated to optimized structural properties.
IN VIVO TORSION TESTING, AGE ON RAT BONE STRUCTURE
Note (7/83):
Administratively terminated. Investigator transferring to Nashville, TN, VAMC.

	Total Funding	Personal Svcs
83	$67,774	$50,740
84	$65,934	$18,807
85	$67,257	$44,798

Bone In-Vivo and In-Vitro Stress and Strain Patterns: Influence of Age and Activity (new title)

SPENGLER, DAN, M.D. 626 NASHVILLE, TN
PROJECT 1
LAST REPORT, PROGRESS 06/85

ASSOCIATES: Keller, TS

STRAIN GAGE; MECHANICAL PROPERTIES; PIEZOELECTRIC; ALLOMETRY

Objective: To investigate in vivo & in vitro stress & strain patterns in rat cortical bone & in vitro stress & strain patterns in primate cortial bone to determine the effects of age, activity & diet on mechanical, morphological, piezoelectric & biochemical properties of cortial bone.

Plan: Male Sprague Dawley rats are instrumented with strain gages in vivo in order to determine the strain pattern present during locomotion throughout maturation & in the mature animal. A specially designed toroid (non-contacting magnetic pickup) was used to record the piezoelectric (current flux) response of bone. Normal (caged), hypoactive (simulated weightlessness), and hyperactive (voluntary and involuntary exercise) rats are examined. In vitro mechanical evaluation of bone are then performed on both rat and primate long bones.

Method: At one week intervals, beginning at 3 weeks of age in vivo strains and currents are recorded from the femora of growing rats, after which the animals are sacrificed and in vivo bending and torsion tests are performed in order to determine structural and material properties. Bending, torsion and fatigue tests are also performed on immature and mature primate cortial bone.

Results: Both hypoactivity and hyperactivity can retard the development of bone in the maturing rat resulting in weakened bones. Thus it appears that an optimum stress range exists, above or below which the bone responds negatively. Maturation itself results in an increase in mechanical strength which is predominately associated with changes in bone geometry. A quantitative relationship between bone formation and stress environment is presently being investigated from which clinical treatment methods for age and activity related bone disease processes can be developed.

Biomechanical Evaluation of the Repaired Canine Meniscus
SPENGLER, DAN, M.D. 626 NASHVILLE, TN
PROJECT 2
LAST REPORT, FINAL 06/85

ASSOCIATES: Keller, TS

Meniscus; Repair; Biomechanics
Objective: To evaluate one technique for inducing healing by producing a localized synovitis. This study should give us much needed information converning the success of this repair technique and the resiliency of the repaired meniscus. It should also help us make a more rational choice among those procedures currently available for repairing the meniscus.
Plan: Tears will be produced in the menisci of dogs, reparied with non-absorbable suture, and a localized synovitis developed.
Method: At 3 weeks, 6 weeks and 12 weeks, the dogs will be sacrificed and the menisci subjected to biochemical and biomechanical evaluations to determine the adequacy and strength of repair.
Findings: Localized synovitis and suturing was not found to produce any healing of the experimentally produced meniscal tears in the dog as evaluated biomechanically and biochemically. During the course of this study a highly effective method of evaluating the mechanical properties of meniscal tissue was developed, however, and it is hoped that this technique may be applied to evaluate future meniscal repair procedures.

-0- -0-

Clinical Trials with the Cochlear Implant Prosthesis
SPITZER, JACLYN B., Ph.D. 689 WEST HAVEN, CT
PROJECT 1
LAST REPORT, PROGRESS 10/84

ASSOCIATES: Gardiner, LJ Kirchner, JC Richardson, FL

COCHLEAR IMPLANT, AUDITORY PROSTHESIS, PROFOUND HEARING LOSS, SENSORINEURAL HEARING LOSS, ASSESSMENT STRATEGIES, GUIDELINES FOR PATIENT SELECTION, REHABILITATION

This year was the start-up phase for the Cochlear Implant project. The following was accomplished: equipment has been largely obtained; personnel has been hired for the Research Audiologist, Speech-Language Pathologist, and Program Coordinator positions; recruiting for the Aural Rehabilitation Specialist position is continuing; a Procedural Manual which details the specific methods for each subsection of the Cochlear Implant protocol has been drafted: tapes of speechreading stimuli with a male and female speaker have been constructed; a symposium regarding the Current Concepts in the Treatment of Profound Deafness was planned and held (4/30/84) with attendance by professionals from a six state area. Regarding an investigation of the "Relationship among electronystagmography, audiologic, and self-report descriptors of dizziness in a veteran sample", the data were extracted from ENG tracings and questionnaire responses were re-organized. Data from this retrospective study are in the process of preparation for computer analysis. Assistance of the Common Resource Statistician has been solicited.

	Total Funding	Personal Services
83-	$300	-0-
84-	215,746	$96,484
85-	161,394	102,294

Development of a Camera for Application in Sensory Aids for the Blind
STEELE, RICHARD D., Ph.D. 640 PALO ALTO, CA
PROJECT 1
LAST REPORT, PROGRESS 09/85

Blind, reading-aid, camera

OBJECTIVES: To develop a prototype computer-based, adaptable portable reading aid using a high resolution, hand-controlled camera which acquires images of inkprint for processing and display both in analog form (via Optacon, Sterotoner, low vision display) and as computer readable codes for input to speech synthesizers, personal computers or Braille displays. The camera will operate on uncontrolled text from 6 points to 14 points high, with a large tolerance for hand tracking error. Microcomputers will analyze the camera's images using image processing techniques and optical character recognition techniques, and will use the results in driving the output displays.

RESEARCH PLAN: (1) test image processing subsystems on large computer, (2) design, build and test input camera and output display interface board, (3) integrate input and output components with the central mciroprocessors, (4) develop capabilities of the integrated system to produce reading aid prototype, (5) clinically test and improve device operation using blind subjects.

METHODOLOGY: The camera will contain a high resolution (128X256) retina to acquire character images. Automatic motion detection, thresholding and magnification control will employ image processing techniques. Tactile and/or audio feedback will guide handtracking of blind users. Acquired images will be identified and transmitted over a standard interface as if from a computer terminal.

STATUS: Research plan itmes (1), (2) and (3) are complete. The systems capabilities are being developed under (4) for subsequent clinical testing (5).

	Total Funding	Personnel Services
83-	$ 84,675	$ 37.180
84-	$ 79.714	$ 46.380
85-	$ 24.508	$ 16.586

Weight Transfer Using Biofeedback and Electrical Stimulation
STERLING, HAROLD, M.D. 605 LOMA LINDA, CA
PROJECT 2
LAST REPORT, PROGRESS 10/85

ASSOCIATES: McNeal, DR

Weight transfer, Electrical stimulation, Biofeedback, Stroke

OBJECTIVES:

1. To construct a Weight Transfer - Feedback Stimulation Trainer (WT-FST).
2. To use the WT-FST at Rancho Los Amigos Hospital (Rancho) as an integral part of preambulation and ambulation of 40 stroke patients.
3. To determine the usefulness of the WT-FST.
4. To construct a second WT-FST, develop instructional manuals, and train personnel at the Jerry L. Pettis Memorial Veterans Hospital in Loma Linda, Ca, in the use of the WT-FST so that it may be incorporated into their gait training program.

RESEARCH PLAN: A major phase of gait training for the hemiplegic following a cerebrovascular accident or head injury is teaching them to transfer weight and maintain weight bearing on the involved limb during ambulation.

The project is based upon a concept called Positional Feedback Stimulation Training, developed and evaluated under a previous V.A. Project, which was shown to markedly improve volitional control of treated joints of the upper and lower extremities.

METHODS: It is expected that by judicious use of the WT-FST, the therapist will be able to initiate ambulation training earlier, progress the patient through the training program more rapidly, and set higher functional goals for the patient to meet by the end of the program.

RESULTS TO DATE:

40 control subjects have been studied. The prototype Positional Feedback Stimulator has been constructed. Several test subjects have started training. A second stimulator will be constructed and delivered to the Loma Linda VAH to expedite testing subjects at this hospital. It is anticipated that the data collection will require an additional year to provide adequate clinical assessment.

	Total Funding	Research Service
83-	$ -0-	$ -0-
84	$ 92,445	-0-
85-	$ 92611	-0-

Optimum Prosthetic Foot Characteristics for the Dysvascular Below Knee Amputee
STERLING, HAROLD, M.D. 605 LOMA LINDA, CA
PROJECT 1
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Perry, J

SACH FOOT BK AMPUTEE GERIATRICS

OBJECTIVES: The purpose of this project is to identify the influence SACH heel stiffness and length of ankle heel have on the BK amputee's knee control and weight bearing pattern.

RESEARCH PLAN: Dysvascular below-knee amputees will be studied. During the first year the effects of the heel stiffness will be measured by inserting cushions of commercial grade soft, medium, and hard will be placed in an experimental SACH foot to replace the patients usual prosthetic foot. Testing will be done in two circumstances. The initial series will be conducted in which the heels are interchanged on the same day with the patients having a period to become accustomed to each. If this information proves non-significant the patients will be fitted with different heels and asked to use them for two weeks before another test is done.

METHOD: All testing will be conducted in the Pathokinesiology Laboratory. Gait measurments to be made include footswitch, stride analysis for gait velocity, single support time and foot support pattern, dynamic electromyography of the vastus lateralis, biceps, femoris, gluteus maximus and rectus femoris, visual vector display and motion analysis of the hip, knee and ankle. These data will be analyzed to compare the vector demands, muscle response and foot support patterns with the type of heel used.

RESULTS TO DATE: Mechanical evaluation of foot characteristics, with 4 grades of heel foam cushions has been completed. Patient evaluations are progressing in the Pathokinesiology Laboratory at Rancho Los Amigos using patients from Loma Linda VAH and Rancho Los Amigos using interchangeable feet with varying heel density, attempting to find the best combinations of foot-heel characteristics for improving gait.

	Total Funding	Personnel Service
83	$ -0-	$ -0-
84	$ 37,565	-0-
85	$ 29,374	-0-

Efficacy of Multiple Input Phoneme Therapy in the Treatment of Severe Expressive Aphasia (title change)
STEVENS, ELAINE R. 402 TOGUS, ME
PROJECT 1
LAST REPORT, PROGRESS 06/85

APHASIA; VERBAL APRAXIA
OBJECTIVE: The purposes of this project are to: (1) Demonstrate that patients classified as severe expressively aphasic will develop single word and phrase level communication as a result of Multiple Input Phoneme Therapy (2) Demonstrate that concomitant changes in other modalities will occur as a result of Multiple Input Phoneme Therapy; (3) Develop a specific word list based on the MIPT hierachy that can be used by other speech and language pathologists; and (4) Futher study the length of time necessary for patients to complete the 22 steps in this therapy program.
RESEARCH PLAN & METHODS: Both in and out-patient veterans diagnosed as severely-profoundly expressively aphasic will be divided into two groups: one receiving traditional therapy procedures; the other MIPT. Each patient will be seen for two to three therapy sessions per week for a ten month period. Pre and post levels of performance will be carefully documented via standardized testing as well as baseline tasks. Additionally, performance will be charted at the 3, 6, and 9 month points.
RESULTS TO DATE: This is a relatively new therapy technique, however, to date 24 patients have been studied, many of who had received and failed other therapy techniques. All attained communication skills far in excess of what could be attained or predicted via traditional therapy procedures. Stevens, E., and Glaser, L: Multiple Input Phoneme Therapy: An approach to Severe Apraxia and Expressive Aphasia, Proceedings of the Conference: Clinical Aphasiology, 1983. Stevens, E., and Glaser, L: MIPT: Treatment of Apraxia and Expressive Aphasia, paper presented at ASHA Convention, Cincinnati, Novemember 1983. Pending publication Stevens, E., "From Sterotypes to Purposeful Speech." in Assessing and Treating Acquired Apraxia of Speech, (Paula E. Square, Editor).
Further investigation of this approach is pending.

	Total Funding	Personnel Svcs
F/83	-0-	-0-
F/84	-0-	-0-
F/85	$1,450	$1,450

Fitness Improvements and Physiological Responses to FES Exercise
SURYAPRASAD, A. G., M.D. 552 DAYTON, OH
PROJECT 3
LAST REPORT, INITIAL 01/85

ASSOCIATES: Glaser, RM Feinberg, SD Gupta, SC
Miles, DS

Wheelchair confinement can lead to a deterioration of one's physical fitness because of insufficient or inappropriate exercise. Furthermore, paralyzed limbs tend to waste away because of disuse muscle atrophy and bone demineralization. Poor circulation of blood in these limbs may result in thrombus formation and decubitus ulcers. These complications could hinder rehabilitative efforts & lead to costly medical care. It appears that more knowledge needs to be acquired as to how the physical fitness of paralyzed patients can be improved by effective for the disabled (wheelchair/arm crank ergometry), and more recently in functional electrical stimulation (FES) exercise of paralyzed leg muscles, suggests that higher levels of physical fitness may be achieved with combinations of these exercise modes. Therefore, primary objectives of this research project are as follows:

1 - Develop standardized exercise protocols utilizing FES of paralyzed muscles for aerobic and anaerobic fitness evaluation, and exercise conditioning.

2 - Compare metabolic cardiovascular and pulmonary responses to electrically induced exercise of paralyzed muscles with the same exercise tasks being performed voluntarily by able-bodies individuals.

3 - Determine peak oxygen uptake and cardiopulmonary responses for electrically induced leg extension exercise and voluntary arm crank/wheelchair ergometer exercise performed separately and in combination.

It is anticipated that data derived from this project will provide important basic information concerning: techniques to enable higher levels of fitness to be achieved in wheelchair confined patients; performance capabilities and limitation of paralyzed muscles for FES exercise; and organ system adjustments to FES exercise stress.

	Total Funding	Received [illegible]
83	$ -0-	$ -0-
84	$ 18,000	$ -0-
85	$ 66,097	$ 32,297

IMPROVED EFFICIENCY AND REDUCED PHYSICAL RISKS FOR WHEELCHAIR LOCOMOTION

SURYAPRASAD, A. G., M.D. 552 DAYTON, OH
PROJECT 1
LAST REPORT, FINAL 07/84

ASSOCIATES: Glaser, RM

Our research has focused on problems associated with wheelchair confinement and locomotion. Objectives were to: 1 - evaluate metabolic and cardiopulmonary stresses of manual wheelchair locomotion over various terrains, 2 - evaluate physical fitness of wheelchair users via exercise stress testing. 3 - improve physical fitness of wheelchair users via arm exercise programs and 4 - improve wheelchair design to increase efficiency and reduce stresses. During this past year, functional electrical stimulation (FES) of paralyzed legs has been incorporated into this research. For this, a computer controlled closed-loop electrical stimulator system was developed for evaluation and training of quadriceps muscles. Using knee extension exercise, a progressive intensity exercise protocol was tested over a 12-week period. Six spinal cord injured subjects volunteered for this experiment. Results indicated that this stimulator system and protocol could be used to strengthen these muscles in a gradual manner so as to avoid injury due to the osteoporotic bones. Oxygen uptake and pulmonary ventilation were found to be linear with load weight. It is unknown, however, if cardiovascular adjustments are sufficient to permit high intensity FES exercise for prolonged periods of time. To determine the feasibility of locomotion via FES of paralyzed muscles, a wheelchair was modified to permit propulsion via back and forth movements of the legs. It was found that both paraplegics and quadriplegics could operate this "leg propelled vehicle" with various degrees of success. More research needs to be conducted in using FES of paralyzed muscles in conjunction with voluntary exercise of functional muscles to promote higher levels of physical capability and rehabilitation in the paralyzed.

F.1'83	F.1'84	F.1'85
-6-	-0-	-0-

Rehabilitation Medicine - A Single Unit Study of Muscle Afferents in Human Movement.
SZUMSKI, ALFRED J., Ph.D. 652 RICHMOND, VA
PROJECT 1
LAST REPORT, FINAL 11/83

ASSOCIATES: Lamb, CR

A laboratory has been established at the McGuire VA Medical Center with electrophysiological capabilities to monitor and record single unit nerve potentials from muscle receptors in awake, unanesthetized humans. The overall objectives of the program was to study the role of the alpha motor-fusimotor systems in human normal and pathological movement.

This initial program which is now terminated, has provided for the assembly of the major electronic equipment, training of the Co-Principal Medical Investigator, and the fabrication of a highly accurate joint measuring device specifically designed to measure active or free joint movement in the saggital plane.

Normal subject results substantiate the accuracy of receptor identification criteria, and contrary to some published reports, preliminary results indicate spontaneous firing of some muscle spindles at rest, and the facilitation of spindle activity by remote muscle contraction; indicating that some muscle spindles are subjected to driving at rest and during certain reflex and voluntary maneuvers. Further testing in the normal is necessary to quantitate this mechanism. Patients need to be studied to monitor this facilitory activity in hyperactive states.

TOTAL Personnel share
FY '83 - $12,656 $ N/A

Implementation of Digital Measurement of Aural Acoustic Immittance
THOMPSON, DAVID J., Ph.D. 544 COLUMBIA, SC
PROJECT 3
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Robinette, LN

OBJECTIVE: The purpose of the project is clinical implementation and evaluation of a programmable acoustic-immittance instrument to support quantiative measurement of aural acoustic immittance.
RESEARCH PLAN: This computer peripheral device, with capacities far exceeding those in analog acoustic-immittance instruments, is being developed for clinical measurements in four phases: (1) modification of the digital instrument, (2) development of control software via host computer, (3) laboratory validation on normal ears, and (4) clinical evaluation on ears with hearing loss.
RESULTS TO DATE: Work during the first project year produced completion of phase I and development of basic software for data acquisition and storage, data measurement/analysis, and graphing routines for computer screen and digital plotter (phase 2). The second project year has produced software for additional measures of the acoustic reflex and for higher-level reduction/analysis of data (phase 2), laboratory assessment of the digital instrument (phase 3), and evaluation of the system on normal ears (phase 3). Results of the laboratory studies demonstrated the superiority of the operating characteristics of the digital system to non-digital instruments. Preliminary data from normal ears revealed potential for significant impact on clinical process through increased efficiency and speed in routine clinical measures, capacity for rapid implementation of new procedures, and support of automated quantitative measurements.

Total Funding Personal Services

83	-0-	-0-
84	-0-	-0-
85	$121,858	$92,234

INVESTIGATION OF THE ACOUSTIC REFLEX IN ELDERLY PERSONS
THOMPSON, DAVID J., Ph.D. 674 TEMPLE, TX
PROJECT 2
LAST REPORT, FINAL 09/83

ASSOCIATES: Robinette, LN

ACOUSTIC REFLEX, AURAL ACOUSTIC IMMITTANCE, AGE
THE PRINCIPAL INVESTIGATOR HAS BEEN TRANSFERRED FROM OLIN E. TEAGUE VETERANS CENTER, TEMPLE, TX TO DORN VETERANS HOSPITAL, COLUMBIA, SC ON 10-01-83, WHERE THE RESEARCH PROJECT WILL BE CONTINUED.
The primary goals of this research project are the development of improved quantitative measurement of the human acoustic reflex and the study of age as an important source of intersubject variance in acoustic reflex measurement. Subjects are persons with normal hearing in the 20 to 79 year age range, partitioned into groups according to age decades. The acoustic reflex is measured with an aural acoustia immittance instrument interfaced to a computer. Aural acoustic immittance measures include the pressure-immittance function, static immittance, and the acoustic reflex (threshold, latency, adaptation and input/outpuat function).
The current phase of the project includes an investigation of acoustic reflex latency and the development of prototype softwave for control of a digital acoustic immittance instrument. These efforts will provide the means for advancement in clinical measures through improved quantitative assessment of aural acoustic immittance.

	Total Funding	Personnel Serv
83	$137,214	$52,392
84	$183,737	$79,386
85	$230,280	$126,648

Effects of Real-Time Biofeedback on the Modification of Dysarthric Speech
TILL, JAMES A., Ph.D. 600 LONG BEACH, CA
PROJECT 1
LAST REPORT, PROGRESS 10/85

ASSOCIATES: Light, RW

DYSARTHRIS, BIOFEEDBACK, RESPIRATION, SPEECH, SPEECH RATE, PARKINSON'S DISEASE, ATAXIA

OBJECTIVES: The purpose of this project is: 1) to investigate the effectiveness of computer controlled real-time high resolution color visual biofeedback in inducing mild to moderate changes in respiration and speech rate among dysarthric patients, and 2) to measure other speech parameters that may covary with changes in speech rate and respiration.

RESEARCH PLAN: Twelve cerebellar ataxic and 12 Parkinson subjects will be compared to normal control subjects during time-series experiments that induce change in respiration and speech rate. Measures of vocal fold movement, fundamental frequency, speech intensity, & speech intelligibility will be made in addition to the measures of speech rate and respiration. Simultaneous real-time extraction of all parameters except intelligibility and rate will be made by dedicated analog instruments connected to a laboratory computer. The computer will control the biofeedback display on the basis of the analog input.

METHODS: Noninvasive dynamic estimates of lung volume during speech will be obtained from a repsiratory inductance plethysmograph (Respitrace). A separate microprocessor device (voice Identification, PM-300) will extract fundamental frequency and intensity. Electroglottographic data will be used to track vocal fold movement. Speech rate will be counted on-line by an observer. Intelligibility will be judged by listeners from tape recordings.

	Total Funding	Personnel Services
83	$ -0-	$ -0-
84	-0-	-0-
85	$ 16,666	$ 6,250

Predicting the Visual Abilities of Partially Sighted Persons

TRIMBLE, JOHN, Ph.D. 578 HINES, IL
PROJECT 2
LAST REPORT, PROGRESS 07/85

ASSOCIATES: Lambert, RW

VISUAL IMPAIRMENT, LOW VISION, CONTRAST SENSITIVITY, LETTER RECOGNITION, FACE RECOGNITION

We have made significant progress in the first year of this three year project. Upon calibrating our visual stimulus, we discovered that the actual contrast of the sinusoidal grating displayed on the cathode ray tube (CRT) decreased with increasing spatial frequency. Accordingly, the acutal contrast of the visual stimulus at high spatial frequencies (e.g., greater than 10 cycles/degree) was considerbly less than anticipated. We decided to investigate this effect further since it could cause significant artifacts in contrast sensitivity measurements.

A thorough review of the literature produced only three references to the effect: Campbell and Green (1956) stated that they had checked for the effect but did not find it: Morgan and Watt (1982) and Hess and Baker (1984) both found it. Only Morgan and Watt (1982) offered a theoretical foundation for it.

Both the scarcity of literature on the effect and its potential significance prompted us to thoroughly investigate the mechanisms that produce it. We found that the extent to which the contrast of the grating decreases at high spatial frequencies is a function of the intensity profile of the CRT beam. If the beam is treated as the impulse response of a linear spatial filter then the decrease in contrast with spatial frequenices is exactly predicted by its two dimensional Fourier transform.

These results have been submitted for publication and are already being used in vision research laboratories in Chicago and Cambridge, England.

	Total Funding	Personnel Services
83	-0-	-0-
84	$63,114	$12,854
85	$107,100	$35,306

Videotex for Disabled Veterans
TRIMBLE, JOHN, Ph.D. 578 HINES, IL
PROJECT 1
LAST REPORT, FINAL 02/84

VIDEOTEX, INFORMATION SYSTEMS, DISABILITY
The objective of this project is to develop a method for rapidly conveying timely information to disabled persons. The project utilized Videotex, a new technology for conveying textual information over broadcast television. The project's research plan incorporated the following steps:
1. Surveying a population of disabled veterans to determine their needs for information concerning their disability;
2. Developing a computerized relational database containing information that was determined to be relevant to veteran's needs;
3. Broadcasting this information to hospitalized, disabled veterans using a commercial videotex system; and,
4. Determining user satisfaction with the information that was provided, and the way in which it was delivered.
While the videotex delivery system was operational, there was considerable enthusiasm over its use. Disabled veterans on the spinal injury service created their own videotex magazine, and regularly contributed items on topics ranging from sports to veteran's organizations to consider its use for delivering information directly to veteran's homes as nationwide service became available. Unfortunately, the project was terminated after only 12 months. The technical reason for this termination was the slow progress in national marketing and development of commercial videotex. However, a consortium of videotex service corporations was recently formed to resolve this problem. Current marketing research suggests videotex will achieve a significant market penetration within five years.

F.Y'83 $-0-
F.Y'84 $-0-
F.Y'85 $-0-

Preliminary Development of CAD/CAM Systems for Lower-Limb Protheses
VANDERBY, RAY JR., Ph.D. 535 CHICAGO, (LAKESIDE), IL
PROJECT 1
LAST REPORT, INITIAL 07/84

ASSOCIATES: Childress, D

COMPUTER DESIGN PROSTHESES

Computer-aided design (CAD) and computer-aided manufacturing (CAM) are influencing most technical fields and a beginning has been made in the use of these procedures in prosthetics. We are proposing to begin a program of activity in CAD/CAM, examining computer-aided-design of sockets using finite-element techniques. We also propose work on computer-aided prosthesis alignment (CAPA). Thus, we are proposing projects at the first stage of the prosthesis-making process and at the last stage. In between these stages are the technical aspects of CAM (numerical-controlled milling of sockets, etc.). Much of the technical detail of the middle-stage has already been worked out by Davies in England and we hope to integrate those technical procedures with the work of these proposals to form a demonstration program in computer-aided-design and computer-aided-manufacture of prostheses.

	Total Funding	Personnel Svcs
83	-0-	-0-
84	$ 17,690	-0-
85	$ 175,805	$ 32,195

Efficacy of Remote Delivery of Aphasia Treatment by TEL-Communicology
VAUGHN, GWENYTH R., Ph.D. 521 BIRMINGHAM, AL
PROJECT 1
LAST REPORT, PROGRESS 10/85

REMOTE HEALTH CARE DELIVERY/TEL-COMMUNICOLOGY/ALPHASIA TREATMENT
PROJECT, PURPOSE AND OBJECTIVES: The purpose is to investigate the efficacy of clinician/computer TEL-communicology delivery of aphasia treatment by comparing: (1) TEL-communicology with Face-to-Face delivery, based on health care delivery criteria statistics measuring: (a) availability, (b) accessibility, (c) acceptability, and (d) cost-effectiveness.
PLAN: Male veterans, 80 years or younger, with first left hemisphere thromboembolic CVA and a PIGA score of between the 10th and 90th overall percentile will receive six months' treatment of aphasia at four VAMC's: Birmingham (Study Center) and New Orleans, Little Rock, and Miami (Field Centers) to determine the relative efficacy of the two delivery systems in rehabilitating the communicative skills of aphasic patients.
METHOD: Subjects will receive pre and post, neurologic and sensory evaluations, and pre, 8, 16, and 24-week speech evaluations. A control group will receive only Face-to-Face treatment; an experimental group will receive only treatment by TEL-Communicology. The same stimulus variables will be used in the treatment of each group. Data collected will determine rate and amount of improvement in each of the two groups.
FINDINGS, RESULTS, CONCLUSIONS: The logistics of providing Face-to-Face clinic delivery (1) prevent large numbers of patients from receiving needed treatment, and (2) force treatment to be based on factors other than the rehabilitative needs of the patient. Success of TEL-Communicology will offer the opportunity to reduce cost and increase the scope of rehabilitative services for veterans with aphasia. During the three years of the project, forty-eight subjects entered the project. Final analysis of the data is being carried out.

FY'83	FY'84	FY'85
$489,302	$582,568	$550,675.

Total amount of personnel service dollars, provided in support of this project for each of the three fiscal years is as follows:

FY'83: $369,858
FY'84: $460,928
FY'85: $486,775

Investigation of a simplified internal knee prosthesis
WALKER, PETER S., Ph.D. 525 BROCKTON, MA
PROJECT 4
LAST REPORT, PROGRESS 09/85

ASSOCIATES: Cochran, T

Objective: To develop an internal knee prosthesis, interfacing directly to boney surface, without requiring cement or tissue ingrowth.
Research Plan: The plan was to develop a computer model of the knee geometry and mechanics, for prosthetic component geometry, to carry out laboratory and analytical studies of press-fit and other interfaces, and to determine if a press-fit interface could be augmented by a compliant layer.
Methodology: The goal was to determine whether a total knee replacement could be designed using press-fit of the components directly on to bone, or with a springy layer of velour interposed, without the need for cement or porous ingrowth. The first stage was to obtain a three-dimensional model of the average knee, including the structure and mechanical properties of the cancellous and cortical bone on to which the artificial knee would be affixed. A finite element analysis showed that press-fitting was equivalent to cementing, only if a perfect fit was achieved at surgery. Experiments showed that this was not usually achieved, but that a velour layer compensated for minor mismatch in fit. Experiments in sheep confirmed that a velour layer reproducibly formed a protective layer at the component-bone interface, but that a direct metal interface involved a bone response where a natural fibrous layer was formed. Based on all of the data, a new Kinematic II Press-Fit total knee was designed. Special fins were added to carry the various shear and rotatory forces acting across the knee. This knee has now been used over the past 18 months on 20 patients. The indications have been the younger and more active patients, but encouraged by the excellent results, the indications are now being expanded. To obtain the best possible alignment at surgery, a new accurate instrumentation system has been developed. This system is extremely simple and compact, and is in keeping with the aims of reducing costs of the total knee procedure, while maintaining high quality results.
Plans for next 12 months: Analysis of histological sections from sheep patella, to compare press-fit and compliant interfaces. Computer model and dynamic testing of 'generic' type of press-fit total knee inserted in knees to test surgical and design variables. Clinical follow-ups of press-fit total knees, started in patients in February 1984.

FY'83	FY'84	FY'85
$39,100	$134,090	$123,352

Total amount of personnel services in support of this project for each of the three fiscal years is as follows.

F/83 $ not available
F/84 $ 66,884
F/85 $ 89,540

A Motion-Guiding Load-Bearing Frame for the Knee
WALKER, PETER S., Ph.D. 525 BROCKTON, MA
PROJECT 3
LAST REPORT, FINAL 10/85

ASSOCIATES: Cochran, T

Objective: To design external joints for the knee which guided normal knee motion, and to incorporate them in a new leg brace design.
Research Plan: To determine 'average knee motion', to design external joints, to model knee mechanics with external joints of different design, and to design and evaluate a new leg brace.
Methodology: Knee motion was determined using cineradiography on volunteers, and using static and a dynamic test rigs on specimens. Computer models were generated which displayed ligament length patterns and tibial-femoral contact joints, depending on external joint design. A computer program was written to optimally design the external joints.
Clinical Relationship: External joints have been incorporated into a leg brace and are now being tested in patients with various knee problems.
Findings, Results or Conclusions: It was proposed that a more effective external knee joint mechanism could be designed by taking into account the complex motion of the normal knee. Two separate studies determined the amounts of rotations and displacements which occurred as the knee flexed and extended. The normal ligament length patterns and the adverse effects of imposing abnormal motions were also determined. By using the above data and by constructing the 3-D geometry of the knee using new sectioning techniques a computer model of average knee mechanics was formulated. With this model, a computer-graphics program was written to design the external joints. The design is based on pins moving in slots to precisely guide the motion. The external joints have now been incorporated in an "Accuflex" knee brace. The brace is currently undergoing clinical evaluation for indications including chronic knee instability, protection after knee ligament injuries and surgery, and in prophylactic situations. It is expected that production will be expanded in the future and that there will be other applications of the external joints for the treatment of knee joint problems.
Patient Care Impact: The work has already made a scientific contribution at several key conferences, and in journals. The new leg brace itself should result in improved treatment for knee instability and injury problems, and will help to stimulate improved treatment for knee instability and injury problems, and will help to stimulate improved designs from others in the field.
Economic Impact: The work will result in an improvement in leg brace design which should enable patients to be rehabilitated quicker and with better clinical results. Other more complex problems involving external fixators can also now be solved whereas at present there is no solution available.

F/'83	F/'84	F/'85
$54,350	$66,149	$36,145

Total amount of personal service dollars provided in support of this project for each of the three fiscal years is as follows

F/'83 $39,014
F/'84 $46,140
F/'85 28,048

THE EFFICACY OF SURGICAL & REHABILITATIVE PROCEDURES OF THE KNEE
WEBER, EDWARD R., M.D. (104) 598 LITTLE ROCK, AR
PROJECT 1
LAST REPORT, FINAL 10/83

ASSOCIATES: McLeod, PC Haynes, DW

INSTRUMENTATION; KNEE INJURY; KNEE RECONSTRUCTION; IMPLANTABLE PROSTHESES

OBJECTIVES: To develop new instrumentation for testing cadaveric knee specimens and to use this instrumentation to study knee injury, reconstruction techniques, patella mechanics, and implantable prostheses. Also, to make the information available to the orthopaedic community.

METHODS & CLINICAL RELATIONSHIPS: A new test apparatus has been designed and constructed, and it is in the final test and verification stage. This new system will permit testing cadaveric specimens in any angular position and load associated with normal gait, and a flexion angle up to one hundred ten degrees. The knee specimen may be rotated about a vertical axis passing through the hip and ankle, while under body weight load for viewing or x-raying from any direction. Also, the tibial rotational drive and varus/valgus angulation drive may be easily disengaged to permit the knee specimen to be stabilized by its natural geometry, body weight force, and quadricep force. This new apparatus will be used to study further the characteristic changes in knee functions as related to injury and disease, and their correction. The primary areas for studies will be the efficacy of various reconstruction techniques for correcting deficiencies in the anterior cruciate and other ligaments, patella mechanics, and the characterization of the more widely used total knee prosthesis.

Meanwhile, testing has proceeded using the existing knee apparatus. Six research papers have been abstracted, four of which were read at the Orthopaedic Research Society meeting, and three submitted to the Journal of Bone & Joint Surgery for publication.

FY'83 - $60,500
FY'84 - $ -0- No record of personnel service dollars
FY'85 - $ -0- funded in FY 83

Evaluation of Powered Wheelchairs and Their Steering Systems

WEIBELL, FRED J., Ph.D. 665 SEPULVEDA, CA
PROJECT 3
LAST REPORT, PROGRESS 04/85

ASSOCIATES: Bonebakker, AD Mehta, A Cohen, M
Naliboff, B

Wheelchair, Power Steering, Paraplegic, Quadraplegic, Handicapped

This is a project to compare a newly designed van-compatible wheelchair and a high-performance conversion of an Everest and Jennings (E&J) Model 3P chair with a standard 3P wheelchair. All three are to be tested with and without power steering. The evaluation is intended to determine both the relative merits of the different wheelchairs in everyday use and the benefits and/or disadvantages of power steering of the normally castered wheels or of an additional wheel that takes the place of the castered wheels when power steering is engaged. The hypothesis is that power steering will provide improved stability on laterally sloping surfaces and over rough or hilly terrain.

A test course has been set up at the Sepulveda VA Medical Center which includes all of the conditions under which the wheelchairs are expected to operate. This course will be used for both an engineering evaluation of the chairs and training of participants. Following the engineering evaluation, each of the three wheelchairs will be operated for one week by each of the fifteen who presently use powered wheelchairs in their daily lives. The participants will use the chairs in all of their usual activities. Upon completion of this test phase, the wheelchairs will be improved as indicated by the results of the initial evaluation. Following these improvements, each participant will use each of the chairs for a second one-week evaluation. Prior to and following each evaluation period, each participant will be required to operate each chair through a prescribed sequence of maneuvers and conditions on the test course to provide both objective and subjective data.

Preparation of the chairs and installation of instumentation is nearly complete.

	Total Funding	Personal Svc.
F/83	$34,819	$982
F/84	$28,326	$6,220
F/85	$12,433	$2,426

Student Projects in the Development of Replacement Ligaments and Tendons Using Polylactic Acid-Filamentous Carbon Composites
WEISS, ANDREW, M.D. 561 EAST ORANGE, NJ
PROJECT 64
LAST REPORT, FINAL 04/85

ASSOCIATES: Alexander, H Langrana, N Gona, A

Artificial ligaments and tendons; knee kinematics; knee stability; in-vitro fibroblast cell cultures
PROJECT OBJECTIVES: The objective of this research is to develop techniques for the evaluation and study of human knee kinematics with the eventual development of artificial ligaments and tendons. There are two phases to this research. The first part is the development of techniques for the theoretical analysis of the effect of knee ligament placement on knee stability. The second part is the development of an in-vitro fibroblast cell attachment to the implant materials and the production of new collagen.
PLAN: Two graduate students under the direction of the principal investigators are developing the techniques necessary to: 1) geometrically evaluate the knee, 2) develop mathematical and computer techniques to kinematically and dynamically evaluate knee function, 3) pursue techniques to grow mammalian fibroblast cultures, and 4) develop techniques to evaluate normal, chemical, and mechanical effects on fibroblast monolayers.
METHOD: Rat tendon fibroblast cells (RTF cells) have been isolated from 14-day old Sprague-Dawley rats. These cells have been cultured on carbon filament and other synthetic fibers and 1) examined with scanning electron microscopy, 2) analyzed for growth rate, 3) pulsed with C(supra-14) proline tracer to determine collagen synthesis rates, and 4) treated with hormones to stimulate cell growth. In order to investigate the ligament constraints in the knee joint, a cadaver knee was mounted in a rig which kept the femur and the tibia in a specified position. K-wires were implanted along the insertion sites of the MCL, the LCL, the ACL and the PCL. CT scans of the knee at 5 mm distances were taken. These scans were transferred to a computer in order to generate a data base for the tibia, the femur, and the tibial and femoral insertion locations for the various ligaments. Three-dimensional computer graphics analysis programs were developed to view the bones with or without ligaments, and to investigate the deformation of the ligaments.
FINDINGS: Collagen synthesis rates have been shown to be directly related to growth rates and cell densities. Collagen synthesis rates of rat tendon fibroblasts (RTF) cells were very much different on the carbon fiber compared to culture dishes due to the fibrous nature of the carbon substrate. Attempts to stimulate RTF cell growth on carbon fiber using FGF, MSA, or electrical stimulation were unsuccessful. It was possible to stimulate cell growth with FGF when the cells were grown at low serum concentration.

The computer graphics techniques necessary for this research were described in previous reports. The KT-1000, developed by the MEDmetric Corporation, was used to determine average values for anterior and posterior travel during standardized drawer tests. Thirty-seven subjects were

F.Y.'83	F.Y.'84	F.Y.'85
$30,954	-0-	-0-

We have no record of funding [illegible] in F.Y.'83 for this study.

WEISS, ANDREW, M.D. 561 EAST ORANGE, NJ
PROJECT 64

examined. Twenty showed ACL deficiency and fifteen showed PCL deficiency. The mean of the drawer test was superimposed upon the computer model to determine the ligament elongation due to drawer. A model for the load distribution among the ligaments was utilized based upon the draw elongation data.

CLINICAL RELATIONSHIP: This project provides information on the dynamics of tendon cell growth and protein systhesis on carbon fiber scaffold materials. The computer approach provided the first documented method for investigation of load sharing without selective cutting of ligaments.

A Tactile Aid for the Treatment of Sensorineural Hearing Loss and Aphasia

WERTZ, ROBERT T., Ph.D. 612 MARTINEZ, CA
PROJECT 1
LAST REPORT, FINAL 03/84

ASSOCIATES: Divenyi, PL Skalbeck, G Saunders, FA

We investigated tactile representation of auditory stimuli for improving speech discrimination in patients with severe sensorineural hearing loss and auditory comprehension in patients suffering global or Wernicke's aphasia. Study patients wore a tactile belt on the abdomen. The belt converts frequency, intensity, and temporal auditory information to tactile patterns that can be perceived on the skin. Stimuli were generated by a computer analog system and presented in three modes--auditory, tactile, and auditory-tactile combined--in a modified random assignment of treatments design. Baseline performance was followed by 20 treatment sessions ten in each of two modes, and post-treatment performance. Treatment stimuli were environmental sounds. Criterion measures were administered pre-and post-treatment. Results were mixed. All subjects in both populations displayed improvement on the treatment tasks. However, performance by sensorineural patients post-treatment ranged from 0-19% improvement in the auditory mode, 0-47% improvement in the tactile mode, and 0-48% improvement in the auditory-tactile combined mode. Post-treatment performance on the criterion measure showed improved performance on five to nine subtests across subjects. Aphasic patients displayed post-treatment performance ranging from 0-14% improvement in the auditory mode, 11-18% improvement in the tactile mode, and 3-16% improvement in the auditory-tactile combined mode. Post-treatment performance on the primary criterion measure ranged from 0-19% improvement.

FY'83 - $96,900
FY'84 - $28,192
FY'85 - $-0-

The amount of personnel service dollars provided in support of this project are
$
FY'83 - 64,641
$
FY'84 - 18,480

Capuchin Monkeys as Aides for the Severely Disabled
WILLARD, MARY JOAN, Ph.D. 526 BRONX, NY
PROJECT 1
LAST REPORT, PROGRESS 04/85

This proposal is an attempt to determine the feasibility of using small trained monkeys as aides for severly disabled individuals. The objectives include: 1) The standardization of training procedures for teaching monkeys a basic repertoire of skills. 2) The redesign of equipment which allows the disabled user to direct, reward, and punish his animal helper. 3) A directory of new skills which can be taught to monkeys. 4) The placement of trained monkeys with new owners. 5) The evaluation of all placements. 6) A cost/benefit analysis for the disabled recipient and the health care system. 7)An analysis of the type of organization that can train and place simian aides on a larger scale. 8) An exploration of the sources of support for a non-profit simian aide program.
Progress has been made in meeting the following objectives:
1) Approximately 2/3rd's of the training procedures used in teaching a basic repertoire of skills have been standardized and described in a 100 page illustrated training manual as well as instructional videotapes. 2) The shock/buzz units used to discipline the monkeys have been reduced in size and weight and variable level shock has been incorporated into the design. 3) Liquid reward dispensers are being replaced with solid food dispensers which are more highly reinforcing. 4) Six high level quadriplegics are now simian aides, one C-6 level quadriplegic will be given a simian aide in 1/85 for a 6 month trial. 5) Canada, Argentina and Israel are now beginning their own simian aide programs. Training material and primate selection information is being provided to them at no charge.

FY'83	FY'84	FY'85
$65,020	$95,095	$128,306

The amount of [illegible] service dollars provided in support of this study for each of the three years is as follows

FY'83 not available
FY'84 - $11,427
FY'85 - $40,547

Implementation of Extended Physiological Proprioception for Prosthesis Control
WINTER, WILLIAM G., M.D. 554 DENVER, CO
PROJECT 2
LAST REPORT, PROGRESS 11/85

ASSOCIATES: Carlson, L

The objective of this project is to further long-established investigation into better methods of controlling a state-of-the-art upper extremity prosthesis, the Utah arm. To the present, contracts are being negotiated through the research and supply offices, Denver VAMC, with the co-principal investigator's laboratory at the University of Colorado to enable this research project to begin. Once this is consummated, this project will commence. We hope that it will represent the beginning of a fruitful collaboration between the Denver VAMC with its well-established orthopedic rehabilitation medicine, and prosthetic services, together with the co-principal-investigator's well established laboratory at the nearby University of Colorado in a project which has received significance VA support through the years. The goal is the implementation of a sophisticated yet simple and reliable proprioceptive feedback system for immediate fine control of the world's most advanced upper extremity prosthesis, the Utah arm, with its particular application for unilateral or bilateral above-elbow amputees.

	Total Funding	Personnel Services
83	-0-	-0-
84	-0-	-0-
85	$48,934	$2,962

Evaluation of Tubular Internal Fixation Plate for Fracture Management (title change)

WOO, SAVIO L-Y, Ph.D. 664 SAN DIEGO, CA
PROJECT 2
LAST REPORT, PROGRESS 01/85

ASSOCIATES: Coutts, RD Garfin, SH Amiel, D
Akeson, W

INTERNAL FIXATION PLATES, ASIAL STIFFNESS, BENDING STIFFNESS, BONE STRESSES, MECHANICAL PROPERTIES

The overall objective of this project is to determine whether significant advantages can be obtained from internal fixation of diaphyseal fractures using plates with improved design. Specifically, our goal is to test the newly developed design criteria, i.e. moderate bending and torsional plate rigidities are needed for early immobilization in order to achieve fracture healing without bone shortening and/or angulation, and low plate axial rigidity is desirable to minimize stress (strain) shielding of the underlying bone during the post-union remodeling process. A new plate with a tubular cross section is made of stainless steel filled with polyethylene. This plate has the aforementioned desired rigidity characteristics and will be used in a canine unilateral midshaft femoral osteotomy mode. A traditional solid stainless steel plate of identical external geometry will be used in a separate series of animals wih similar osteotomy. In addition, it is also our goal to test whether such a low axial rigidity plate can prove to be advantageous to the recovery of full structural properties of the underlying bone following plate removal.

At the present time, the evaluation of the bone lying beneath both the traditional solid stainless steel (control) and the new tubular (experimental) plates is being performed using x-ray, geometric measurements, histomorphometric measurements and biochemcial techniques. Specifically, a comparison is being made between the actual physical properties of bone and the structural and mechanical properties obtained by biomechanical bending, axial and torsional testing. Histomorphometric data has shown that, on the average, bone porosity is higher for the control solid stainless steel plate, whereas, there is an increase in new bone growth and less porosity for bone lying beneath the experimental hollow plate. This information correlates well with the bioengineering tests performed. With further comparison and study of these test results, we hope to provide more insight into the problem of localized osteopenia that occurs with the use of internal fixation plate systems.

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Structural and Functional Properties of Normal and Repaired Ligaments

WOO, SAVIO L-Y, Ph.D. 664 SAN DIEGO, CA
PROJECT 4
LAST REPORT, PROGRESS 01/85

ASSOCIATES: Gelberman, R Amiel, D Garfin, S
Akeson, W

LIGAMENT HEALING, MECHANICAL PROPERTIES, STRENGTH, LAXITY, ACTIVITY FACTORS
The objective of this research is to evaluate the ligament repair process in a model synovial joint system. A variety of activity conditions will be used in order to determine which set of conditions will maximize the speed and strength of the repair or healing of ligaments. To achieve this objective it will be necessary to determine the influence of a wide range of physical factors such as rigid immobilization, cage activity, normal activity, intermittent controlled passive motion and rigorous daily exercise programs on the size and strength of normal and repaired/healing ligaments.

To date, we have studied medial collateral ligament healing with and without surgical repair using a canine model. The evaluation of the quality of ligament healing and repair has included correlative studies using morphologic, biomechanical and biochemical techniques. Specifically, we have studied healing ligaments subjected to various regimens of repair and early mobilization over a six week time period. We have focused on the biomechanical properties of the ligament repair site and the areas of the ligament proximal and distal to the repair. The structural and mechanical properteis obtained were in turn compared to the biochemical results and histological appearance of each of these areas and very good correlations were found. We are currently performing experiments over a twelve week time period to further define proper clinical regimens that may be used to provide better healing of ligmaent structures. Our goal is essentially twofold: to improve the structural integrity of the healing ligament to ameliorate problems of knee joint instability, and to improve the material properties of the healing ligament substance as well.

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DEVELOPMENT OF A CAMERA FOR APPLICATION IN SENSORY AIDS FOR THE BLIND
WOOD, SALLY L., Ph.D. 640 PALO ALTO, CA
PROJECT 1
LAST REPORT, FINAL 08/83

ASSOCIATES: Steele, RD

BLIND, READING-AID, CAMERA

OBJECTIVES: To develop a high resolution hand-controlled camera which acquires images of inkprint and converts the images into computer readable codes for input to speech synthesizers or braille displays. The camera will operate on uncontrolled text from 1/20 to 1/2 inch high, with a large tolerance for hand-tracking error. The camera will be an input unit of a "component reading machine."

RESEARCH PLAN: (1) Test image processing subsystems on a large computer. (2) Build breadboard optics which use image processing software. (3) Design, build and test three prototype microprocessor based cameras for use with commerical test-to-speech systems.

METHODOLOGY: The camera will contain a high resolution linear retina to acquire character images. Automatic motion detection, thresholding and magnification control will use image processing techniques. Optimal tactile or modified stereotonor feedback will guide handtracking. Acquired images will be identified, and corresponding computer codes will be transmitted over a standard interface as if from a standard terminal. The output type (speech, braille, low-vision display), quality and cost can be individually determined.

STATUS: Research plan item 1 is complete and item 2 is almost complete. The architecture for item 3 is established, and alternative designs are being evaluated.

CLINICAL RELATIONSHIP: This device will be useful to blind and low-vision people capable of using a handheld camera with tactile, auditory or visual cues for tracking.

This project has terminated under Dr. Wood, who has left the facility. Dr. Richard Steele will continue this project as Principal Investigator.

Rosamund Svec.

FY'83 - $83,000 $ N/A
FY'84 - $-0- -0-
FY'85 - $-0- -0-

An Auditory Prosthesis for Sensorineural Hearing Loss

YUND, E. WILLIAM, Ph.D. 612 MARTINEZ, CA
PROJECT 1
LAST REPORT, PROGRESS 03/85

ASSOCIATES: Efron, R Simon, HJ

SENSORINEURAL HEARING LOSS, SNHL, INTENSITY-RESPONSE FUNCTION, BINAURAL DIPLACUSIS, HEARING AID, PITCH INFORMATION, DICHOTIC TESTING

The objective of this research project is to develop a better hearing aid for individuals with sensorineural hearing loss (SNHL). The idea behind the research is the analysis of SNHL in individual patients not in terms of physiological causes, but rather in terms of the ability of the patient's auditory system to accurately process spectral or pitch information. Recent research indicates that pitch information processing ability of normal hearing subjects can be characterized by means of psychoacoustic experiments using simultaneous dichotic pure tone stimuli and our theoretical model of pitch processing. Of particular interest is the stage of the model (the intensity-response or I-R function) that corresponds to the ear's ability to determine the intensity of a sound and generate the appropriate neural response for that intensity. While it is well known that the ear with SNHL has deficits in its I-R mechanisms - threshold elevation alone establishes that - no techniques have been available to measure the I-R function throughout the range of sound intensities above threshold. We have measured I-R functions in SNHL subjects at frequencies from 500 to 4000 Hz. These I-R functions have less steep than normal slopes at moderate intensities while they have their steepest slopes at the highest intensities where normal I-R functions show saturation. We are currently testing, by means of digital signal processing, the effect of amplification to normalize the output of the I-R mechanism in each of the half-octave bands from 500 to 4000 Hz. Corrections for binaural diplacusis and other pitch problems will also be tested.

Funding Allocation	Personal Services
FY'83 - $ 91,095	$ 41.448
FY'84 - $ 150,959	58.563
FY'85 - $ 96.000	69.080

Computer Models for Designing FES Systems for Paraplegic Standing and Walking
ZAJAC, FELIX E. III, Ph.D. 640 PALO ALTO, CA
PROJECT 2
LAST REPORT, INITIAL 04/85

ASSOCIATES: Perkash, I

Functional Electrical Stimulation, Paraplegics, Major Technological Problems, Computer models, Engineering Control Principals, Static and Dynamic Properties

Restoring motoric function to spinal cord injured person by functional electrical stimulation (FES) of their paralyzed muscles have been explored for over 20 years. It has been demonstrated that muscles activated by FES can enable paraplegics to rise from a chair, stand and walk. These pioneering efforts have identified major technological problems prohibiting routine clinical prescription of FES as a means for paraplegics to regain function of their legs. One of these problems is the lack of computer models both for designing FES systems to control standing and walking in paraplegics, and for determining the trade-offs among the different designs. Knowledge obtained from studying these trade-offs should reduce the amount of experimentation needed to develop clinical FES systems for restoring mobility to paraplegics.

We propose to develop a computer model based on modern engineering control principles that can be used to study stimulate FES induced standing and walking in paraplegics. The model will include the dynamic interactions among the gound, the legs, the torso, the arms, and the static and dynamic properties of the stimulated muscles.

The computer model will be used first to study, design and evalute FES feedback control strategies, needed to induce stable standing in paraplegics. The performance of these FES systems will be based on both subjective and objective measures of stimulated standing ability. The subjective evaluation will be based on a animated graphics display of a simulated standing paraplegic. The objective measure will be a scalar, or score, based on the FES system's ability to maintaining stability and minimize muscle fatigue.

Total Funding Personal Services

83	$ -0-	$ -0-
84	-0-	-0-
85	$45,400	$ 40,000

The Spinal Locomotion Pattern Generator in Humans
ZOMLEFER, MICHAEL R., Ph.D. 640 PALO ALTO, CA
PROJECT 1
LAST REPORT, PROGRESS 09/83

ASSOCIATES: Gaines, RF

LOCOMOTION, STEPPING, SPINAL CORD

Objective: This purpose of this study is to determine whether spinal cord injured humans possess some form of spinal "pattern generator" for locomotion.

Research Plan: We looked at almost two dozen spinal-cord injured volunteers over the past one year period.

Methodology: Volunteers patients were suspended in a modified parachute harness over a moving treadmill belt. The sole stimulus to the subject was plantar contact of his foot with the belt. Leg movement was recorded with a video system, while electromyographic activity was measured from lower limb muscles.

Clinical Significance: This project will help establish the connection(s), if any, between animal models used in spinal walking as they apply to humans.

Results: Thusfar, 22 subjects have been studied. Ten of these subjects showed rhythmic electromyographic patterns when their legs were moved by the investigators. One subject demonstrated rhythmic activity at the end of the experiment, when his legs were held immobile above the treadmill. These results have been submitted in abstract form for presentation at the 1983 meeting of the Society for neuroscience (Boston, Massachusetts).

	Total Funding	Personnel Services
83-	$ -0-	$ -0-
84-	$ -0-	-0-
85	$ 43,195	$ 28,525

Question: 1. C) Provide evidence to indicate a balance of rehabilitation research projects between projects such as spinal cord regeneration, practical research, including prosthetic development, and rehabilitation towards full employment and independent living.

Answer: The balance in Rehab R&D projects underway is demonstrated by the following distribution of projects:

Prosthetics/Amputation/Orthotics — 53 projects ($4.7 million in FY 85)

Internal Joints and Prostheses (15), Diagnostic Procedures (14), Prosthetics/Orthotics (9), Surgical Procedures (6), Mobility (3), Manipululative Devices (2), Therapeutics (2) Gait Analysis (1), and Maxillofacial Prostheses (1).

Spinal Cord Injury — 38 projects — ($4.7 million in FY 85)

Diagnostic Procedures (13), Neuromuscular Controls (6), Internal Joint/Prostheses (5), Surgical Procedures (4), Manipulative Devices (3), Mobility (3), Prosthetics/Orthotics (2), and Other (2).

Sensory Aids — 28 projects — ($2.2 million in FY 85)

Deafness and Hearing Impairment (7), Diagnostic Procedures (6) Speech Impairment (6), Blindness and Visual Impairment (5), Internal Joint/Prostheses (1) Manipulative Devices (1), and Therapeutic (2).

Other — 18 projects ($3.5 million in FY 85)

Rehab R&D Centers (2), Rehab R&D Units (3), Aging (3) and Miscellenous (7).

Question: 1D) Explain how grants are awarded, including the bidding process, RFP requirements and peer reviews. How do you monitor projects progress?

Answer: The Rehab R&D Service does not issue grants. The Rehab R&D program is primarily an intramural program conducted at VA Medical Centers (VAMCs) where VA facilities and staff can direct their efforts to resolving health problems of veterans. Proposals from non-VA facilities are considered for funding under the following conditions: 1) the proposal is submitted through a local VAMC, 2) the proposal is reviewed and approved by the R&D committee and Human Studies Committee, when applicable, 3) a VA physician or scientist must be co-principal investigator, and 4) VA patients should be involved in clinical trails.

The Associate Chief of Staff for R&D (ACOS/R&D) in the local VAMC coordinates the submission of research proposals for the Medical Center Director following a prescribed format. Proposals submitted for funding by the Rehab R&D Service in VA Central Office are reviewed by a special merit review board for scientific merit and relevance. The board makes recommendations to the Director regarding funding and scientific aspects of a proposal. The progress of Rehab R&D projects is monitored through written reports which are required to be submitted regularly, review of published articles and reports, site visits and oversight by staff both at the local level where an R&D Committee is responsible for at least annual review and at the Central Office level.

REORGANIZATIONS

Question:

For each of the proposed reorganizations, please provide:

A) detailed analysis of how the number of FTEE to be transferred was determined.

B) the justification for the transfer and how the FTEE for each office involved was determined; and

C) the net effect on FTEE levels for each office involved in the transfer and the net overall effect for the VA FTEE level in terms of workload and productivity projections.

Issue I: Office of Administration.

Answer I-A: The transfer of the Memorial Certificate Program to the Compensation and Pension Service in DVB and the Audio Visuals Service to the ADA for Public and Consumer Affairs carry with them their existing FTEE.

Answer I-B: In the case of the Presidential Memorial Certificates Program, it was felt that as a benefit of military service, the Program properly belonged in the Department of Veterans Benefits. This is also a logical placement due to the fact that roughly 75 percent of the requests for certificates are generated by actions taken in the VA regional offices.

The Office of the ADA for Public and Consumer Affairs bears the responsibility for the VA's public affairs program in which Audio Visuals plays an integral part. The transfer of this unit will insure a more integrated approach to the VA's audiovisual activities, provide better coordination, and insure compliance with policy, high standards of quality and consistency of approach. In its current placement in the Office of Administration, requests for services are fulfilled but not reviewed at a higher level.

In each case, the entire function and associated resources (funding and average employment) will be transferred.

Answer I-C: The FY 1987 staffing ceiling of 7 FTE in Memorial Certificates and 32 FTE in Audio Visuals will remain the same. The present employees will move with the function. We anticipate productivity will increase in these functions as a result of better organizational placement. The transfer will have no effect on workload.

Issue II: Realignment of the Office of Construction to the Department of Medicine and Surgery.

Answer II-A: **The number of FTEE to be transferred was based on a transfer and consolidation of facility planning, design, and construction functions into the DM&S rather than maintaining a split of such functions between O/C and DM&S. The reorganization involves consolidating the current FTEE of the Office of Construction (O/C) and DM&S's Facility Engineering Planning and Construction Office into a single organization, namely the Office of Facilities reporting directly to the Chief Medical Director. Combined staff will be funded from the Construction (minor) projects General Administration appropriation. In making his decision to transfer O/C as a unit to DM&S, the Administrator also announced his intention to transfer 10 FTEE from O/C to the ADA for Management and 3 FTEE from O/C to the Office of Budget and Finance (Controller) to support improved oversight of the construction program.**

Answer II-B: **On October 31, 1985, the Administrator announced his intention to transfer the Office of Construction, as a unit to DM&S. This decision was consistent with the long range organizational recommendations contained in the April 1985, Booz, Allen and Hamilton Inc./RTKL Associates Inc. consultant study -- a comprehensive review of the VA's health care facility design and construction process. The transfer and consolidation of O/C into DM&S will:**

- **create a unified system with a single focus of management authority, responsibility and accountability;**
- **create opportunities for the elimination and/or reduction in over-lapping authorities, duplication, fragmentation and redundancies in the existing organizational structure;**
- **enable users to more actively influence the health facility planning and construction process;**
- **assure the level of support required by the facility programs of the other Departments (DVB, DMA) in the cooperative way that VA Medical Centers currently support VA regional offices and VA national cementeries; and,**
- **ensure that the facilities utilized in the field are appropriately planned, designed and constructed to enhance the care and service provided to the nations veterans, consistent with the economical use of scarce dollar resources.**

Based upon the announcement by the Administrator of his intention to transfer O/C to DM&S, the Chief Medical Director established a Work Group composed of senior DM&S and O/C staff to advise him on this reorganization effort. The organization that was unanimously proposed by the group consolidated the function, staff and resources of O/C and DM&S's Facility Engineering Planning and Construction Office. This proposal was subsequently approved by the CMD and the Administrator.

Answer II-C:	FY 1986 Current Estimate	FY 1987 Estimate	Changes (+,-)
MAMOE	664	591	-73 1/
Construction; minor projects	684	733 2/	+49

1/ Seventy-three (73) FTEE will be transferred from Medical Administration and Miscellaneous Operating Expenses (MAMOE) to the Construction, minor projects appropriation.

2/ The FY 1987 estimate for Construction, minor projects is based on the allowance of 673 FTEE, the transfer of 73 FTEE from MAMOE to the proposed Office of Facilities, the transfer of 10 FTEE from the proposed Office of Facilities to the Associate Deputy Administrator for Management, and the transfer of 3 FTEE from the proposed Office of Facilities to the Office of Budget and Finance (Controller).

The net overall impact of this reorganization will be a more effective and efficient organizational unit capable of fulfilling the Agency's facility/construction-related workload with fewer FTEE resources. The consolidation of functions and staff into a single organizational unit will result in the elimination and/or reduction in fragmentation, overlapping authorities, and duplication of effort.

Issue III: Insurance Consolidation.

Answer III-A: It was assumed that consolidation would not reduce the amount of direct labor needed to produce Insurance endproducts. Using DVB budget projection for FY 1986 and FY 1985 actual costs, the ratios of available hours represented by supervisions, clerical overhead and leave as distinct from direct labor were identified. This breakdown was verified by comparing these figures to the staffing charts at each site. Costs of support services were based on FY 1985 actual costs and staffing levels; however, these costs were straight-lined for the life cycle. Since support services provide assistance to many organizational elements, the estimates of local managers were relied upon for the percentage of the total available hours which the support services devote to Insurance work.

Having isolated direct labor, the only step remaining was to determine how many FTEE in supervisory positions would have to be transferred to maintain a reasonable span of control. The Philadelphia Insurance Center was used as a model for the ratio of supervision to direct labor since it had the lowest ratio.

Answer III-B: The objectives of consolidation are to improve operational efficiency by reducing supervision and clerical overhead in relation to direct labor and to improve cost-effectiveness by reducing the operating costs of the program. In order to determine the most efficient and cost-effective operational structure, a one-site processing model was developed. Staffing for the one-site model was based on the methodology described above. All direct labor FTEE at both existing sites was retained, clerical overhead at the largest of the two existing sites was retained, and supervision was augmented at the largest site in order to maintain a reasonable ratio between it and direct labor. Costs for implementing and maintaining this one-site model at either of the two existing sites were then developed and compared to the present two-site operational costs. The establishment of a one-site operation in a third or neutral site was not costed because it would have been far too costly and disruptive.

Answer III-C: The study which supported the consolidation move was based on current staffing levels of 427.6 FTEE for the Insurance Operations activities in both offices and 258.5 FTEE for Support Services, for a total of 686.1 FTEE. With one-site processing, we expect to be able to operate with 397.1 FTEE in the Insurance Operations Activities and 250.6 FTEE in Support Services, which represents a total savings of 38.4 FTEE. The consolidation proposal would close all Insurance Activities at the VAROIC in St. Paul, and result in an Overall net reduction of 38.4 FTEE. Since this reduction comes primarily from supervision and clerical overhead, productivity would increase after the transition period has passed. The workload should remain unchanged regardless of the number of operating sites.

Issue IV: Transfer of the Office of Data Management and Telecommunications to the Department of Veterans Benefits.

Answer IV-A:

The FTEE to be transfered from the Office of Data Management and Telecommunications (ODM&T) to the Department of Veterans Benefits (DVB) represent the positions most directly associated with support of the benefits delivery systems. These include: 63 FTE which now comprise the Benefits Automation Service/ODM&T in Washington D.C., 237 FTE in the three data processing centers (DPC'S) which are devoted to programming of DVB systems (63 in Austin, 124 in Hines and 50 in Philadelphia); 41 FTE in central office and the DPC's which perform DVB system audit functions; and 21 FTE for management.

Answer IV-B:

The functions to be transfered are those which are unique to the support of DVB programs. Placing the functions under DVB control will allow the Department to direct the development of ADP systems associated with the delivery of services and benefits. The transfer is intended to accomplish the following objectives:

- establish a DVB ADP Planning and systems development capability;
- give DVB direct budgetary control over and accountability for use of ADP resources;
- expand end-user involvement in planning and systems development activities;
- allow for better integration among systems; and
- facilitate the consideration of and implementation of new approaches to DVB systems design.

Answer IV-C:

The transfer will not change the VA FTEE level, but will move 362 FTE from ODM&T to DVB. The functions to be transfered are those which are unique to the support of DVB programs. The nature of the functions will not change nor will they be assigned to a different facility.

MEDICAL CARE

Question: 1. With respect to classifying DM&S FTEE as direct or indirect providers of patient care, how are Central Office personnel who are being (or have been) transferred to the field being classified?

Answer: The people transferred to the field from Central Office were administrative personnel (budget analysts and planners). These people, therefore, would be classified as indirect care providers.

Question: 2. How will Vet Center employees and operations be affected by Gramm/Rudman cutbacks? Are Vet Centers experiencing the same percentage of reduction as other direct patient care personnel? Explain.

Answer: The Readjustment Counseling (Vet Center) Program has recently completed a 39 percent expansion in the number of FTEE and Vet Centers which was directed by Congress. The agency plans to maintain the current number of Vet Centers by reducing the contracts side of the program in FY 1986. No further changes in overall program dollars or FTEE will occur in FY 1987. The agency will support the implementation of two Vietnam Veteran Resource Center pilot sites within existing resources.

Vet Centers are not experiencing the same 1 percent reduction as other direct patient care personnel. The recent expansion of the Vet Centers was mandated by Congress. This "front loading" of the program we understand to be in the interest of completing its time-limited mission as quickly as possible. For this reason, and because the agency projects that the program's FTEE and funding will be reduced in the out years as its mission is completed and the need for and utilization of services decreases, VA program resources will remain constant for FY 1986 and FY 1987.

QUESTION

Section 1519 of title 38 USC requires "studies and research concerning the psychological, educational, employment, social, vocational, industrial, and economic aspects of the rehabilitation of disabled veterans, including new methods of rehabilitation".

a. Who is responsible for the implementation of Section 1519, the Chief Medical Director, the Chief Benefits Director, or both?

ANSWER

Section 1519 of Title 38 USC directs the Administrator to conduct an ongoing program of research and development for the purpose of advancing the knowledge, methods, techniques, and resources available for the use in rehabilitation programs for veterans. The Chief Benefits Director is responsible for the implementation of this section.

b. Which specific DVB and/or DM&S offices, departments, or services would be involved in the implementation?

ANSWER

The Vocational Rehabilitation and Counseling Service in the Department of Veterans Benefits will be responsible for implementing Section 1519.

c. Please provide information concerning your plans (including resources allocation) for implementing section 1519.

ANSWER

The FY 1987 budget contains $536,000 to carry out identified areas of research and demonstration projects that will improve delivery of or quality and timeliness of rehabilitation services to service disabled veterans.

The VR&C service has developed the following preliminary plan to meet this need:

o Identify research in the field of rehabilitation conducted by other agencies such as the National Institute on Handicapped Research through existing data bases.

o Review rehabilitation research sponsored by the

Department of Medicine and Surgery for applicability to the Vocational Rehabilitation Program.

o Identify areas for research and demonstration projects such as developing a computer-based system to provide immediate retrieval of current information on occupations, colleges, vocational-technical schools, apprenticeship and local employment opportunities. The project would also provide for development of an assessment device to accurately indicate the interests, aptitudes, and abilities of counselees.

o Conduct demonstration projects to improve quality and timeliness of rehabiliaton services to ensure that the knowledge, methods, techniques, and resources available for use in rehabiliation programs for veterans are implemented.

Question: 3. In an October 3, 1985, letter, former Administrator Walters stated:

> the VA continues to test CHAMPUS fee schedules and the results will be analyzed before the VA decides if they are appropriate to use. The VA is continuing further studies of the Medicare fee schedules. When the studies are completed and analyzed, the VA will be in a better position to determine if adaption of these schedules is appropriate.

a. Have you completed your review of CHAMPUS fee schedules?

Answer: Yes.

Question: b. If so, please provide a summary of your analysis of the appropriateness, including the advantages and disadvantages, of the CHAMPUS fee schedules for VA use.

Answer: We tested the OCHAMPUS Fee schedule at two VA Medical Centers. If the OCHAMPUS fee schedule were implemented, it would increase fee medical costs 19% at one facility and 213% at the other. It is felt that VA could not absorb these costs within our available budget and we therefore decided not to use this schedule.

Question: c. If not, when do you intend to complete your review and the analysis of the review?

Answer: N/A.

Question: d. Have you completed your review of Medicare fee schedules?

Answer: Yes.

Question: e. If so, please provide a summary of your analysis of the appropriateness, including the advantages and disadvantages, of the Medicare fee schedules for VA use.

Answer: Adoption of the Medicare fee schedule would involve the VA in contracting with the 56 Medicare fiscal intermediaries. (In meetings with the GAO, GAO staff indicated that they could not get schedule information from the intermediaries). Under our current system for processing bills and without contracts with the FI's, we made the decision not to adopt use of the Medicare fee schedule because of its complexity.

Question: f. If not, when do you intend to complete your review and the analysis of the review?

Answer: N/A.

Question: 4. Public Law 97-72 provided authorization for an annual grant to the Republic of the Philippines of $500,000 through Fiscal Year 1986, for assisting in the replacement and upgrading of equipment and in rehabilitating the physical plant and facilities of the Veterans Memorial Medical Center (VMMC).

Please provide a list (including resources) of the projects for which the grants to the Philippines were used for Fiscal Years 1982-1986 and a list (including resources) of the projects for which the grant would be used in Fiscal Year 1987.

ANSWER: FY 1982 - No projects accomplished. Total grant equalled $50,000.

FY 1983 - No projects accomplished. First $500,000 grant year. Equipment only purchased.

FY 1984 - Repair and Replacement of Steam Condensate and Hot Water lines, Phase one $82,107.

-Repair of Sewage Treatment Plant $20,571.

FY 1985 - General Repair of Outpatient Bldg. $134,131.

- Installation of Electric Fans in Patient Room's and Treatment areas - $1,192.

- Installation of Boiler $3,763.

- Installation of Steam Sterilizer $2,063.

- Installation of Washer/Extractor Laundry Machine $1,364.

- Repair of patient bedside chairs and tables $27,142.

FY 1985 - General repair of Neuro-Psy. Ward #5 $154,081.

- Renovation of existing Laundry equipment - $40,746.
- Repair and replacement of steam/condensate and hot water lines, Phase II $88,938.
- Installation of Roof and water proofing building #3, $60,037.

-Renovation of main kitchen Medical Intensive Care and Coronary Care Units $64,450.

FY 1986, Pending Projects:

- Replace roofs and waterproof buildings, #8, 11 & 12 $150,000.

Replace three elevators in buildings #10, 11 & 12 $90,000

- Renovate operating rooms and Surgical Intensive Care Unit, $150,000.

FY 1986 - Renovate Supply/Warehouse Bldgs. $45,000.

- Upgrade Electrical Distribution System $40,000.

FY 1987 - Projected Projects:

- Renovate Chemistry and Pathology Labs, $44,000.
- Renovate Central Processing $75,000.
- General repair and replacement of water distribution system $165,000.
- Renovate Nurses station wards #1-13 $36,000.
- Replace nurse call systems, Medical, Surgical wards and Intensive Care Units $180,000.

In addition to the above, replacement of the VMMC's Fire Alarm System, telephone system and emergency generator are needed at an estimated cost of $1.2 million. Since 1982, only maintenance and repair projects have been able to be accomplished.

Question: 5. The Veterans Canteen Service has been a self-sustaining activity. For fiscal year 1987, will the Canteen Service be self-sustaining or will it require appropriations to sustain the account? If so, how much?

Answer: If reductions continue over the several years, appropriations will be needed to sustain this account. During 1986 several actions will take place to reduced the obligation level by $8,104,000. These actions include reducing equipment purchases, inventory reductions, shortening operating hours and may include reducing employment through attrition. These actions will also reduce revenues, and may eventually require that an appropriation be granted to the Canteen Service.

Question 6. What are the recommendations made by the Special Committee on Post-traumatic Stress Disorder in its First Annual Report?

Question 6A. Do you intend to implement the recommendations?

Question 6B. If so, what is your timetable for implementation?

Question 6C. If not, why not?

Answer: Public Law 98-528 mandated an Agency report to Congress outlining the Agency's implementation of requirements set forth in Section 110 of that legislation.

Among other things, the Department was required to establish a Special Committee on PTSD to provide advice and guidance to the Agency on PTSD related activities. The Agency's report to Congress is required to include the recommendations which were made by the Special Committee and the Chief Medical Director's views on the Special Committee's recommendtions.

The Special Committee's report, which includes 33 recommendations and the Agency's report which contains the Chief Medical Director's comments on these 33 recommendations were sent, as a set, to Congress on February 18, 1986.

The attached action plan presents a synopsis of the Special Committee's recommendations, the Chief Medical Director's views and comments, actions to be taken to meet the Special Committee's recommendations (if applicable) and offices or staff responsible for actions to be taken. The last column, for the identification of target dates, has been left blank pending meetings between the Special Committee on PTSD and appropriate offices in VA Central Office. These meetings took place on March 12-14, 1986.

Attachment

Section 110, PL 98-528 Post-traumatic Stress Disorder

	Chief Medical Director/Chief Benefits Director Response						
Special Committee's Recommendation	Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#1. Establish PTSD treatment teams at each VAMC with centrally directed FTEE. At least one member of the team to be a psychiatrist.		X			To implement fully would require 344 FTEE and $22 million. Not convinced every VAMC needs PTSD treatment team, but many could. Will support in 1986 if resources available. Will evaluate for 1987 within context of Department priorities.	MH&BSS, ACMD for Clinical Affairs, ADCMD, Director for Operations Resource Management Office	
#2. Designate specialized PTSD Program in each Medical District.		X			To implement fully would require 150 FTEE and $7 million. At present, res. and staffing level constraints & priorities preclude accomplishing this objective.		
#3. Establish reporting system capable of tracking PTSD patients through all aspects of their care.	X				Will begin to develop automated tracking system.	MH&BSS, Readjustment Counseling Service, Special Committee on PTSD, MH SIUG, MIRMO	

Section 110, PL 98-528 Post-traumatic Stress Disorder

Special Committee's Recommendation	Chief Medical Director/Chief Benefits Director Response						
	Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Target Completion Date
#4. Accelerate time table for implementing clinical software packages for VA's ADP system.		X			MH Software package is verified. DM&S highest priority is maintaining CORE. 1987 is earliest year for tracking PTSD patients.	MH&BSS, Special Committee on PTSD, MH SIUG, MIRMO	
#5. In addition to tracking clinical utilization by PTSD patients, recommend that such a data system assess treatment outcome.	X				Will support priority placement of ADP hardware and software development to assist utilization of a PTSD patient tracking and evaluation system.		
#6. VA should conduct epidemiological and demographic study of veterans with PTSD discharged from VAMCs and Vet Centers to show geographical distribution of PTSD patients in comparison of resources allocated for treatment of PTSD.		X			Identifying the geographic distribution of veterans discharged with PTSD can be accomplished. Additional information about prevalence of PTSD disorders will be available from the National Vietnam Veterans Readjustment Study. This information will provide expected incidence of PTSD among veterans in a given county, state or medical district.		

Section 110, PL 98-528 Post-traumatic Stress Disorder

Special Committee's Recommendation	Chief Medical Director/Chief Benefits Director Response						
	Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#6. (Continued)					Current information system for cost accounting can be modified to account for costs attributed to specialized PTSD inpatient units, but cannot be used to account for the cost of treatment for a PTSD patient treated in a general psychiatry ward. However, resource accountability may be included as part of PTSD tracking system.	MH&BSS, Resource Management Office	
#7. Adequate diagnostic evaluations be made to combat veterans regardless of his/her current service-connected status.			X		Joint communications will be issued to clinicians and MAS staff to raise the level of awareness and understanding of PTSD. The Department will develop and offer an examination using uniform protocol for PTSD for combat veterans such as those used for examining former POWs.	MH&BSS, MAS	

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Special Committee's Recommendation	Chief Medical Director/Chief Benefits Director Response Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#8. Protocol be developed to identify veterans 'at risk' for PTSD and applying for care.	X				Special Committee will make recommendations for the development.	MH&BSS, Special Committee on PTSD	
#9. Clinical assessment be offered to veterans fitting 'high risk' profile.[4]	X				Guidance to clinical and administration staff will promote early awareness of the possibility of PTSD and will encourage thorough examinations to assess for PTSD. The PTSD protocol mentioned in recommendations 7 and 8 should include a clinical assessment and should be offered to all combat veterans.	MH&BSS, Special Committee on PTSD	
#10. VAMCs should be provided guidance with regard to clinical assessment of 'high risk' veterans.	X				Develop a Clinical Affairs Letter to include specific guidelines to all VAMCs in regard to clinical assessment of 'at risk' veterans.	MH&BSS, Special Committee on PTSD	
#11. Diagnostic rating scales should be developed and standardized	X				Rating scales will be developed.	MH&BSS, Special Committee on PTSD	

	Chief Medical Director/Chief Benefits Director Response						
Special Committee's Recommendation	Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#12. Clinicians should be educated in psychological and physiological techniques for diagnosing PTSD.	X				These issues will be addressed in training programs for VA health care professionals not associated with the specialized PTSD programs.	MH&BSS, Special Committee on PTSD	
#13. Develop and issue a Mental Health Program Guide describing the various treatment approaches to PTSD.	X				Mental Health Program Guide will address PTSD treatment in general psychiatry inpatient and outpatient programs and specialized PTSD units will be developed.	MH&BSS, Special Committee on PTSD, Field Task force	
#14. Develop criteria for referring specific patients to specific treatment	X				General guidelines are possible, but specific triage criteria are premature.	MH&BSS, Special Committee	
#15. Specific DRGs with appropriate trim points and weighed work units should be developed. 'Pass-through' funding might be a resonable strategy so that present DRGs wil not provide a financial discentive to starting or maintaining specialized inpatient PTSD unit alternatives.				X	Do not agree on 'pass through' funding. A study is underway to address diagnoses of PTSD and the lengths of stay and resources required to treat patients in this category will be taken into account.		
#16. Psychiatric liaison and consultation services be properly staffed at each VAMC.	X				Will encourage each VAMC to strengthen psychiatric liaison and consultation services.		

Section 110, PL 98-528 Post-traumatic Stress Disorder

	Chief Medical Director/Chief Benefits Director Response						
Special Committee's Recommendation	Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#17. There should be systematic coordination and integration of treatment resources from Vet Centers to general medical programs to specialized PTSD programs.	X				A letter from the ADCMD has been sent to all VAMCs encouraging close collaboration. Joint communications are necessary.	MH&BSS, Special Committee on PTSD	
#18. Funding research for PTSD remain a high priority for the VA.	X				Funding PTSD research through the merit review process will remain a high priority for the Department.	MH&BSS, Special Committee on PTSD	
#19. Since PTSD is one the the few medical disorders treated by the VA that is caused by combat exposure, consideration be given to making more research funds available to investigators who wish to study this disorder.				X	PTSD research proposals are reviewed for merit and recommended for funding by the Mental Health and Behavioral Sciences Merit Review Board. Several steps have been initiated to assist VA clinicians interested in PTSD research including guidelines to provide recommendations for improving PTSD research proposals. PTSD should continue to be funded on the basis of merit and peer review.		

Section 110, PL 98-528 Post-traumatic Stress Disorder

Special Committee's Recommendation	Chief Medical Director/Chief Benefits Director Response						
	Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#20. Increase the number of investigators and protocols studying PTSD. Strategies should include (a) additional workshops on developing fundable protocols, (b) mini-residencies in research design, (c) implementation of pre-proposal system, (d) establishment of a new investigator program.	X				Will ask the ACMD for Research and Development to consider these strategies following Spring merit review round.	ACMD for Research and Development	
#21. Ensure that Committee members of the Merit Review Board have an awareness of PTSD and that some members have expertise in this field.	X						
#22. Due to small percentage of VA staff trained in the area of PTSD recommend that the VA develop a national approach to such training.	X				Training efforts have been provided by Readjustment Counseling Service and Mental Health and Behavioral Sciences Service. During this fiscal year, training will be offered to VA health care professionals at VAMCs without designated PTSD programs. Designation of PTSD as a national priority for training for FY 86 will be based on a continuing need for training and funding priorities.	Readjustment Counseling Service, MH&BSS, ACMD for Academic Affairs	

Special Committee's Recommendation	Chief Medical Director/Chief Benefits Director Response						
	Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#23. VA conduct systematic assessment to determine the impact of PTSD edcuational programs presented in relation to the educational needs within the Agency			X		The magnitude of such a study would be both difficult and expensive to design and conduct.	MH&BSS, Office of ACMD for Academic Affairs (RMECs)	
#24. Faculty members within and without the VA system should be identified who may best develop and present educational programs as well as provide consultation to VAMCs.	X				Faculty selection is based on knowledge and expertise on a given topic.	MH&BSS, and Office of ACMD for Academic Affairs	
#25. Educational program initiatives should be centrally prioritized in order to influence the direction of local and regional educational activities.			X		Efforts to plan and execute PTSD training programs require national, regional and local participation. The Continuing education field units have and will continue to successfully identify educational needs and priorities of VA staff within their regional jurisdictions.	ACMD for Academic Affairs, MH&BSS, Continuing Educational Field Units, Readjustment Counseling Service, Social Work Service	

Section 110, PL 98-528 Post-traumatic Stress Disorder

	Chief Medical Director/Chief Benefits Director Response						
Special Committee's Recommendation	Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#26. Educational aids should be updated to include state-of-the-art material.	X				Contingent upon funding priorities.		
#27. Educational activities regarding diagnosis and treatment of PTSD should be directed toward five major audiences: VA clinical staff, VA administrative staff, military personnel, community groups and students in the health professions.		X			PTSD educational programs would assist in the early diagnosis and treatment of patients suffering from PTSD. Educational programs on PTSD have been provided through the regional Continuing Education Field Units (CEFUs). Joint VA and the Department of Defense training efforts have been initiated. Efforts will continue to the extend possible.		

Section 110, PL 98-528 Post-traumatic Stress Disorder

	Chief Medical Director/Chief Benefits Director Response						
Special Committee's Recommendation	Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#28. The Committee recommends that for one quarter, each regional office keep track of all PTSD claims and other mental health claims. Data generated during this 3 month survey would make it possible to review and identify any indications of system-wide or station specific problems affecting disability evaluations.	X				Will provide the Committee with the data. However, the data would be more informative if collected for a longer period (perhaps a year) rather than 3 months. Most PTSD claims take longer than 90 days to adjudicate. Also most appeals take longer to reach the Board of Veterans Appeals.		
#29. A tracking system be established for PTSD claims similar to that established for former prisoners of war.	X						
#30. Recommend that adjudicate boards give presumptive accuracy to information contained in the clinical examination with regard to self-reports of combat exposure if supported by the DD-214.				X	When the DD-214 provides evidence that corroborates the veteran or medical examiner's statement as to PTSD stressor, verification through the U.S. Army and Joint Services Environmental Support Group is not taken. The rating board searches other military records which support a claim of stress related to PTSD.		

Section 110, PL 98-528 Post-traumatic Stress Disorder

Special Committee's Recommendation	Chief Medical Director/Chief Benefits Director Response: Concur	Agree in Concept	Do Not Fully Concur	Do Not Concur	Response/Action to be Taken	Action Office	Expected Completion
#31. There be joint training and cross training between local clinicians and local adjudicators.	X				Cross and joint training efforts are ongoing at VA medical centers and VA regional offices. Will continue to encourage these local PTSD training initiatives.		
#32. Recommend that all relevant information be considered by the adjudication board when processing claims rather than relying exclusively on information from the compensation and pension examinations.	X						
#33. That the Department of Veterans Benefits designate an administrative PTSD coordinator at each Regional Office.	X						

Question: 6.D. The medical care program reforms and management initiative proposals included savings of -6,983 FTEE and -$351 million from treating fewer low priority veterans. Do these savings assume implementation of the Administration's proposed means test or are these savings in addition to the means test savings?

Answer: We do not associate savings with the means test proposal. A means test will help assure that resources are first made available for service-connected and low income veterans. The budget, in a separate initiative, proposes to treat fewer inpatients and outpatients. Veterans having lower eligibility for access to care will be impacted.

Question: 6.E. Please provide an estimate of the administrative costs which would be incurred in order to implement the Administration's means test and third party reimbursement proposals.

Answer: Administrative cost for FY86 to prepare implementation of a means test would be approximately $400,000 (298 FTE hired during September 1986). Recurring costs will be approximately $5,282,000 per fiscal year starting in FY 1987, without taking into consideration any increase costs for increased employee's benefits (e.g. Federal employee's cost of living increases; increased health benefits; etc.).

Estimated administrative costs of implementing third party recoveries effective July 1 are 160 FTE if we are to manage the program in house (approximately $.5M).

Question: 6F. Please provide information concerning the policy changes which resulted in the request to eliminate the Postgraduate and Inservice Training activity under the MAMOE appropriation and transfer of funding for staff training to the appropriation account which supports employee salaries.

Answer: The request to transfer the Postgraduate and Inservice Training Program to the Medical Care appropriation was an operational judgement that the funds for continuing education of VA facility employees should be carried in the same appropriation as the payroll for these employees. This reinforces our belief that continuing education and staff training are basic ingredients of quality health care. The transferred resources will continue to be used to maintain and upgrade the knowledge and skills of VA facility employees. We will manage the program in essentially the same manner as before, but the cost of it will be reflected in the appropriation which benefits from the resources.

Question: 6G. Please provide an explanation of the assumptions used to determine an increase of $178 million due to inflation in the medical care account.

Answer: In addition to the medical care increase of $177,395,000 attributed to inflation, $15.2 million for inflation is included in the equipment request. This $192.6 million is based upon the Administration's economic assumptions. A projected Medical Care Price Index (CPI) of 5.9 percent was applied to the 1986 base of medical non-payroll items (other contractual services, supplies and materials, capital investment and lands and structures). A non-medical CPI of 4.2 percent was applied to non-medical objects (travel, transportation of things, printing, and rents, communication and utilities). The resultant composite increase is approximately 5.6 percent.

Question 7: The DM&S 1985 survey of Veterans Demand for Medical Care at VA facilities stated that: "the VA accepted 92.8% of veterans needing further care and 89% of telephone requests for transfer, and continued in clinics or admitted 97.6% of outpatients requiring further care."

Question 7A: Please provide a breakdown by Medical District and by Region of the percentage accepted by the VA of veterans needing further care and the percentage of telephone requests for transfer, and the percentage of outpatients requiring further care who were continued in clinics or admitted.

Answer: These breakdowns are attached.

[illegible]

1985 Demand for VA Medical Care Study
Percentage of Patients Accepted for Care

	Total Valid Applicants VA Care as a Percent of Total Valid Applicants Requiring Care.	Total Valid Telephone Requests for VA Inpatient Care Accepted as a Percent of Total Valid phone Requests for Inpatient Care, requiring Such Care.	Total Valid Outpatients Requiring Continued Care that Receive Continued Care as a Percent of Total Valid Outpatients that Require Continued Care.
SYSTEM WIDE	92.39	88.62	97.61
REGION 1	92.74	84.66	98.42
District 1	95.27	83.78	99.12
District 2	92.00	84.62	97.79
District 3	91.94	86.15	98.14
REGION 2	90.77	87.50	97.54
District 4	92.58	81.82	98.60
District 5	93.64	84.13	97.67
District 6	83.51	100.00	98.46
District 7	90.61	89.47	97.03
District 8	93.32	95.59	94.48
REGION 3	85.69	89.64	96.38
District 9	76.05	94.00	93.08
District 10	94.11	90.00	98.08
District 11	95.11	95.83	97.58
District 12	82.76	80.46	95.99

	Total Valid Applicants VA Care as a Percent of Total Valid Applicants Requiring Care.	Total Valid Telephone Requests for VA Inpatient Care Accepted as a Percent of Total Valid phone Requests for Inpatient Care, requiring Such Care.	Total Valid Outpatients Requiring Continued Care that Receive Continued Care as a Percent of Total Valid Outpatients that Require Continued Care.
REGION 4	96.42	92.98	98.37
District 13	95.95	91.21	98.49
District 14	96.54	72.50	99.21
District 15	97.74	100.00	98.24
District 16	96.28	95.16	97.17
District 17	96.86	97.01	98.70
REGION 5	94.85	87.50	97.08
District 18	93.42	86.54	96.79
District 21	95.44	96.47	96.69
District 22	95.38	96.23	97.47
District 23	94.83	65.75	97.42
REGION 6	92.90	79.92	98.21
District 25	92.87	82.56	98.71
District 26	92.08	70.89	97.58
District 27	94.10	84.85	97.78
REGION 7	95.09	94.77	96.65
District 19	95.20	95.00	98.37
District 20	94.82	89.53	90.02
District 24	95.25	98.75	92.04

Question 7B: Please provide an analysis of the strengths and weakness in the methodology used and the significance of the findings of the survey.

Answer: While we believe that the study has provided needed information on veterans applying for care, some concerns about the derivation and use of the date are apparent. For example, we are concerned that some of the nuances of the definitions used within the survey may be confusing to VA medical center staff who actually conduct these surveys and gather other supporting information and data. There is no assurance that the data collection itself is without bias or confounding elements. Another obvious weakness is this technique's inability to capture "suppressed demand"--i.e., those patients who are presumed to need medical care, but do not apply for care at VA facilities. Another major weakness of this survey is its failure to discern whether or not patients denied care during one period may, in fact, be accepted for care at another period. Also, most of the decisions associated with the determination that an individual patient "needed care," but was denied care were made by clerical staff on the basis of records reviews. Although we operate records systems with standard rules, there is wide variability among VA facilities as to the thoroughness of recordkeeping.

It should be kept in mind that these were a 2-day and one-week "snapshot" surveys, which did not attempt to take account of fluctuations in workload, availability of specialty and subspeciality resources, and variability of casemix. These do affect a facility's capacity to accept new patients on a given date, or during a particular week. Thus, a survey like this one which suggests 20,000--or more--patients are being "turned away" each month is insensitive to a dynamic environment, is relatively one-dimensional, and may be significantly flawed in that respect. It should also be remembered that the survey's estimate of total turn-aways is a projection, but based only on this one-week data collection period. The survey cannot determine, for example, whether an individual patient turn-away is a repetitious event (in other words, it could be concluded that a specific individual turned away during the survey week is to be turned away again and again throughout the year, which we doubt in fact.)

Even though the survey seems to indicate that a significant number of veterans are "turned away," VA facilities are seen by this survey as accepting for care 90-95% of applicants who seek it as compared to a 60% acceptance rate in 1970. This level of acceptance equates generally with reports provided through the monthly "Summary of Medical Programs" publication, a more traditional VA reporting technique.

In addition, the use of the term "turned away" has been misleading. It gives the impression that these veterans were never treated when, in fact (except for phone calls) veterans were examined and in many cases treated before they were referred to the community for further care or placed on a VA waiting list.

WRITTEN QUESTIONS FROM SENATOR CRANSTON TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

FEBRUARY 5, 1986

QUESTION:

1. Regarding the VA's Loan Guaranty Revolving Fund, the VA's submission indicated that a limitation will be placed on the issuance of new loan guaranties in FY 1986. It stated that the FY 1986 base is $11,986,522,000 and that the amount being sequestered is $515,420,000.

(a) Will there be a specific limitation placed on the issuance of VA loan guaranties in FY 1986 and, if so, at what level will such a limitation be set?

1B. Please indicate specifically how it is planned that such a limitation will be implemented and whether implementation will result in any cases of refusal or withholding of guaranties of any loans as to which a guaranty would otherwise be granted under current laws and regulations.

1C. If any guaranties would be so refused or withheld, please provide an analysis explaining how the implementation of the order would be consistent with the provision in section 252(e) of the Act prohibiting any person who is eligible for a benefit from being denied eligibility by reason of a Presidential order under section 252.

1D. I question the President's authority to order the sequestration of VA loan guaranty commitments in FY 1986. According to the Directors of the Congressional Budget Office and the Office of Management and Budget, in their January 15 report under section 251(a) of the Act, and the Comptroller General of the United States, in his January 20 report under section 251(b), the net effect of the limitation would be to increase FY 86 outlays, and thus the Fy 86 deficit, by $5,350,000. The reason, of course, is that the limitation would directly cause FY 86 receipts of loan-guaranty fees under section 1829 of title 38, United States Code, to decrease.

However, the authorities in the Act for sequestration are expressed in terms of reductions that would reduce outlays and the deficit. Thus, section 251(a)(3)(B) states that "the reductions [in non-defense programs] necessary to eliminate the other half of the . . . adjusted deficit excess, in the case of fiscal year 1986 . . . shall be made in outlays under [non-defense accounts] . . . ." Section 251(a)(3)(F)(iv)(I) further requires that sequestrations "under . . . non-defense programs [other than those to which an exemption or special rule applies] shall be applied on a uniform percentage basis so as to reduce new budget authority, new loans guarantee commitments, new direct loan obligations, and [entitlement spending] . . . to the extent necessary to achieve any remaining required outlay reductions [under section 251(a)(3)(B), quoted above]."

Since the clearly stated mandate in the Act is to make reductions "in outlays" for the purpose of eliminating the FY 1986 adjusted deficit excess and to apply sequestrations "on a uniform percentage basis . . . to the extent necessary to achieve. . . required outlay reductions", there appears to be an absence of authority to sequester any budgetary resource where the effect is not to reduce outlays or the dificit during the fiscal year involved. In this connection, I would also note that the Act contains no authority or requirement to sequester budgetary resources in order to reduce any future year deficit.

(e) Please also advise what is the agency's best estimate of the total amount of FY 86 VA loan guaranty commitments that would be made in the absence of sequestration.

In light of the foregoing, I would appreciate your providing me with a copy of any legal analysis prepared by the Administration in support of the sequistration of VA loan guaranty commitments.

Response:

1 (A): There has been a modification since the time the initial sequestration was taken. First, the initial sequestration process will be discussed. The initial limitation on the issuance of new VA loan guaranties was established at $11,569,123,000. This figure was derived by taking the VA's estimate of $12,084,543,000 and averaging it with CBO's estimate of $11,888,500,000, resulting in an average of $11,986,522,000. 4.3 percent of this average amount ($515,420,000) was then deducted from the VA's initial amount.

Since that time, Congress has increased the base estimate to $18.2 billion. This was accomplished in Public Law 99-255 signed on March 7, 1986. In effect, this increased the pre-sequestration base to $18.2 billion. The 4.3 percent reduction would establish the new guaranteed loan limitation at $17,417,400,000.

1.B. Implementation of the sequester order legally establishes a ceiling on new loan guarantee commitments in compliance with the de facto limitations imposed by Gramm-Rudman. However, it should be noted that Congress has recently passed legislation increasing the new loan guarantee limit base, ceiling prior to sequestration, at $18.2 billion. This action, however, does not exclude the loan guaranty program from sequestration but merely raises the base amount prior to sequestration. At this level, it is felt that the Agency can take steps to insure the operation of the program through the fiscal year.

1.C. The President's sequestration order imposes a de facto limitation on VA new loan guarantee commitments. This limitation is legally binding on the Agency and once the ceiling is reached, the VA is without authority to guaranty any more loans. However, it should be noted, as mentioned in response 1.B., that if necessary the Agency will continue to consider alternatives to insure that the program will operate during the fiscal year.

1D. Under the provisions of Gramm-Rudman, the Directors of the Congressional Budget Office and the Office of Management and Budget are charged with calculating the amounts and percentages by which various budgetary resources must be sequestered in order to eliminate any deficit excess. The sequestration report is subject to confirmation or modification by the Comptroller General before the specified reductions are implemented in the sequestration order issued by the President. As indicated in your question, the sequestration order includes new loan guarantee commitments while at the same time the sequestration report reveals that no savings in outlays for FY 86 will occur. It is our understanding that any change to the sequestration order must come about through congressional action. Even though one may infer from section 251(a)(3)(B) that new budget authority and new loan guarantee commitments in nondefense programs may not be reduced as part of the sequestration process unless outlay reductions are achieved in the same fiscal year, other provisions of the Act, e.g., sections 252(a)(4)(B), and 257 (7), provide for reductions in new budget authority and new loan guarantee commitments as part of the sequestration process, without reference to reductions in budget outlays in the same fiscal year. In addition, the Conference Report, in its discussion of loans, does not limit the sequestration limitation on new loan guarantee commitments to a reduction in outlays.

1(e) VA's current estimate of the total dollar amount of loans to be guaranteed during FY 1986 in the absence of a sequestration is $18.2 billion.

Question: 2. Although $936,000 of the FY 1986 appropriation for the State veterans homes program and $128,000 of the FY 1986 appropriation for the State veterans cemeteries program would be sequestered, the OMB and CBO Directors' reports indicate that no FY 86 outlay savings would be achieved. In light of the issues raised in item 1(d), above, regarding the loan guaranty program, please provide me with a copy of any legal analysis that has been prepared supporting these sequestrations.

Answer: While the sequestration order may not affect budget outlays in FY 86 for these programs, it will ultimately reduce budget outlays of FY 86 funds.

Question 3. The VA's "Program, Project, Activity Detail" reflects a direct loan limitation in the case of each of the six insurance accounts.

(a) Do these limitations conflict with the U.S. Government's contractual obligation to veteran policyholders?

(b) What are the VA's plans for implementing such limitations?

(c) Please explain how implementation would be consistent with the prohibition in section 252(e) of the Act against the denial of eligibility for a benefit.

Response: 3.(a). The Act required that the sequestration order be consistent with the January 20 report of the Comptroller General, who was responsible for determining the statutorily required nature and extent of outlay reductions. Apparently the Comptroller General's report to the President, which included the limitation on loans, was based on the interpretation that: (1) the sequestration requirements of the act would encompass policy loans; (2) and that the Government may lawfully restrict loan availability.

(b) The Comptroller General has concluded that the obligations and outlays for policy loans issued under the six insurance programs are subject to the ceiling limitations imposed by the Act. The 4.3% reduction rate will be applied uniformly to each of the insurance programs.

It was decided to maintain an 11% interest rate for the National Service Life Insurance (NSLI), Veterans Special Life Insurance (VSLI), Veterans Reopened Insurance (VRI), Veterans Insurance and Indemnities (VI&I) and Service Disabled Veterans Insurance (SDVI). Based on the current trend in loan activity this action should be sufficient to stay within the limitation ceilings for the VI&I, NSLI, and VSLI programs. It should be noted that the latter two programs represent 77% of the expected loan activity.

Despite the 11% loan rate, it is anticipated that additional action may be required for the USGLI, VRI and SDVI programs. The USGLI raises a different problem. By law, the interest rate for this program can not exceed 5%. The Agency is continuing to look into ways to determine what steps can be taken administratively to continue the operation of the loan activity for these programs through the fiscal year.

3.(c): As mentioned earlier, the Agency is still looking into what steps may be taken to a) remain within the loan limitation established as a result of PL 99-177, and b) continue operation of the program through the fiscal year. It is felt that additional steps will be required for the USGLI, VRI and SDVI programs.

QUESTION 4: Please advise how, consistent with section 252 (e), the Agency plans to implement the sequestration of appropriations for items that are provided in kind, such as burial flags, headstones, and grave markers.

RESPONSE:

Burial flags and headstones/markers are projects, programs, activities for purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 and therefore, the appropriations to purchase these items are subject to the 4.3 percent sequestration order for 1986. As stated in the Comptroller General's February 7, 1986, opinion to the Honorable G.V. (Sonny) Montgomery, sequestration under this Act does not diminish the entitlement itself, but instead reduces the budgetary resources to make full payment.

As stated above, Section 252 (e) prohibits the denial of eligibility for benefits under the sequester order. In most benefit programs, the restriction requires a reduction in benefits to all rather than a denial of benefits to some. "In kind" benefits, such as burial flags, headstones, and markers, do not lend themselves to benefit reduction. Burial flags, headstones and markers are administered on a contractual basis, which makes them difficult to alter. Because of these considerations, a reprogramming from the Pensions program will be requested to fully fund these "in kind" benefits.

QUESTION:

5. With respect to the Medical care account, please provide for each program, project, or activity a breakdown showing the amounts in the base that are attributed to administrative and non-administrative expenses for purposes of the provisions of section 256(b) and (k), under which certain administrative exxpenses are subject to a 4.3-percent reduction and non-administrative expenses to a maximum reduction of one percent in FY 86.

RESPONSE:

Activity	Non-Admin. Base	Admin. Base	Offset Collection Base *	Total Base	Tot. Oblig. Sequestered
VA Hospitals	$4,993,994	$476,883	$32,094	5,502,971	$70,767
VA Nursing Homes	383,800	42,070	...	425,870	5,647
VA Domiciliaries	93,000	12,977	...	105,977	1,488
Outpatient Care	1,657,200	100,024	...	1,757,224	20,873
Misc. Benefits & Services	330,400	95,163	...	425,563	7,396
Education & Training	460,400	24,744	...	485,144	5,668
Contract Hospitals	139,900	1,349	...	141,249	1,457
Community Nursing Homes	278,400	5,674	...	284,074	3,028
State Home Hospitals	2,900	163	...	3,063	36
State Home Nursing Care	53,000	581	...	53,581	555
State Home Domiciliaries	12,200	372	...	12,572	138
CHAMPVA	82,500	...	...	82,500	825
TOTAL	8,487,694	760,000	32,094	9,279,788	117,878

* Offsetting collections from Non-Federal sources are considered new spending authority and subject to 1% sequestration.

QUESTION 6: A February 6 VA "Fact Sheet" indicated that benefit payments under the Vietnam-era GI Bill and the dependents' and survivors' educational assistance program will be reduced by 8.7 percent; that the subsistence allowances under the rehabilitation program for service-connected disabled veterans will be reduced by 13.1 percent; and that grants under the specially adapted housing and adaptive automobile assistance programs will be reduced by 8 percent. Please explain how these varying percentages were determined pursuant to section 252(a)(1)(B) of the Act.

RESPONSE:

The process used to arrive at the amounts and the resulting percentage reductions is explained as follows:

For each sequesterable appropriation, a 4.3 percent reduction was applied to the total sequesterable budgetary resources. For example, in the Readjustment Benefits appropriation a 4.3 percent sequester was applied to the estimate of new budget authority of $917 million. This budget authority level includes the funds provided in the appropriation ($826 million) as well as the program supplemental request ($91 million).

The 4.3 percent reduction was then applied to each program, project and activity (PPA) as defined in the Conference report of the Continuing Resolution. In the Readjustment Benefits account, the PPA reflected each activity listed in the budget justification submitted to Congress. Attached (Attachment 1) is the PPA report on Readjustment Benefits submitted to Congress as part of the February 1, 1986 report.

For sequestered entitlements, such as the Readjustment Benefits account, benefit payments will have to be reduced to meet the required reduction. Payments for sequestered programs will be reduced between March 1 and September 30 by the percent necessary to reduce the estimate of obligations by the sequestered amount. The payment reductions were determined as follows:

Education and training: The education and training payment reductions were determined by dividing the sequestered level (from the PPA) by the estimated obligations between March 1986 and September 1986. Based upon this methodology, it is anticipated that the 8.7 percent reduction will achieve the sequestered reduction of $33,885,000.

Vocational rehabilitation: In determining the reduction for vocational rehabilitation, it is necessary to examine the composition of this program. The vocational rehabilitation program is made up of monthly subsistence payments as well as providing for books, tuition, and equipment necessary to begin training. It was determined that it would be difficult to sequester the payment for tuition, fees and books as these payments reflect actual costs (already paid to schools), and that the reduction would be taken from the monthly subsistence payments.

It should be noted that the total reduction to the vocational rehabilitation program would be 7.73 percent. This is determined in the same manner as the other activities. However, by excluding the tuition payments, the reduction to the subsistence rates would be 13.1 percent.

Grants: The reduction to the grant program was taken in the same manner as the education benefits. The sequester amount, as identified in PPA, was compared to the obligation estimate during the sequester period. It is estimated that a reduction of 7.85 percent in specially adapted housing and 7.91 percent in adaptive equipment will achieve the sequestered reductions.

A chart (Attachment 2) is provided detailing the methodology used in determining the percentage reductions.

Attachment 1

Page 1 of 1

PROGRAM, PROJECT, ACTIVITY DETAIL
($000)

Agency: Veterans Administration

Account Title: Readjustment Benefits

Account ID code: 29-00-0137-X-1-702-A; 36-0137

Source: Public Law 99-160 (1986 Appropriation)

Program, project, activity	Budgetary Resources	
	Base	Sequester
1. Vietnam era veterans	$ 69,861	$ 28,805
2. Sons and daughters	108,087	4,648
3. Spouses and widow (ers)	10,055	432
4. Vocational rehabilitation	102,774	4,419
5. Housing grants	14,029	603
6. Automobiles, adaptive equipment, maintenance and repair	12,194	524
Total	$ 917,000 1/	$ 39,431

1/ Estimate includes 1986 program supplemental of $91,000,000.

Attachment 2

Readjustment Benefits
1986 Gramm-Rudman
(dollars in thousands)

Program, Project, Activity	1987 Middle Column (incl. suppl.)	Estimate Obligations February	Balance	Sequester	% Reduction
Vietnam era veterans	$686,693	$351,446			
Sons and daughters	110,803	61,873			
Spouses and widow(ers)	10,308	5,447			
Subtotal	807,804	418,766	389,038	33,885	8.71
Vocational rehabilitation	105,356	48,130	57,226	4,419	7.73
(Subsistence)			(33,698)	(4,419)	(13.12)
(in-kind)			(23,528)	-0-	-0-
Housing grants	14,382	6,693	7,689	603	7.85
Automobiles, Adapt. Equipment	12,500	5,871	6,629	524	7.91
Total	$940,042	$479,460	460,582	39,431	8.57

QUESTION 7: Please provide a detailed description and explanation of the treatment of the Chapter 32 Post-Vietnam Era Veterans' Education Assistance program and the Chapter 30 New GI Bill under the February 1 presidential order.

RESPONSE 7:

Concerning Chapter 32, funds for this program are provided to the VA from the Department of Defense (DOD). It is our understanding that while the DOD appropriation that would include these funds is subject to sequestration, DOD has some flexibility in applying such sequestration. Within that flexibility, DOD has decided to fully fund the Chapter 32 program in 1986. Regarding Chapter 30, no appropriations were requested in 1986 for veterans' basic benefits since program eligibility is, in general, dependent on an individual's completion of two years of military service and the program itself has been in existence less than one year.

QUESTION 8: Please explain why, in the "Program, Project, Activity Detail" for the Direct Loan Revolving Fund, the amount shown as being sequestered is "-43,000".

Response: The sequestration amount of $43,000 represents a reduction of 4.3 percent from the $989,000 limitation amount contained in the 1986 appropriations bill, Pub. L. 99-160.

FEBRUARY 7, 1986

Question: 1.a. By what amount over your budget request would the medical care appropriation have to be increased in FY 1987 in order to support an FTEE level of 193,941, the level assumed in connection with the FY 1986 HUD-Independent Agencies Appropriations Act (Public Law 99-160)?

Answer: An estimated increase of $406,307,000 would be required to support an FTEE level of 193,941. This includes the restoration of the $351 million savings from treating fewer nonservice-connected veterans (6,988 FTEE) and $55 million of the $57 million productivity resource reduction (1,860 FTEE). The requested 1987 employment level of 185,093 FTEE plus the 8,848 FTEE (sum of two restorations above) would equal the 193,941 employment level.

Question: 1.b. How many hospital, nursing home, and domiciliary inpatients would be treated and how many outpatient visits furnished in FY 87 if the medical care account were so increased?

Answer: The estimated increase of $406,307,000 would support an additional 74,000 patients treated in VA hospitals and an additional 1,308,000 outpatient visits above the levels requested in the 1987 Budget. The number of VA nursing home and domiciliary inpatients treated would remain the same as requested.

These resources would provide for the restoration of the workload reduction associated with treatment of fewer lower priority veterans (62,000 patients treated and 1,254,000 outpatient visits) and assumes an increase in workload based on the productivity increase (12,000 patients treated and 54,000 outpatient visits).

Question: 2. A. What is the estimated average salary under the medical care account for FY 1987 and what are the components of that average amount?

B. What was the average salary under the medical care account and what were the components of that average amount in FY 1985 and what is it in FY 1986, both as originally assumed in connection with the proposed budget for each year and as actually experienced?

Answer: Question 2 was discussed with your staff by the DM&S Resource Management Staff and it was mutually agreed to delete the requirement for a response to this question.

Question: 3. Please provide the following ratios using constant dollars and assuming appropriate allocations of medical care account funds and FTEF to inpatient and outpatient care programs:

A. The ratios (i) between the amount appropriated in FY 1985 and the numbers of inpatients treated and outpatient visits furnished in FY 1985, and (ii) between the number of FTEE employed in FY 1985 and the numbers of inpatients treated and outpatient visits furnished in FY 1985.

Answer: The 1985 ratios follow:

	(i)	(i)	(ii)	(ii)	
VA Facilities	WKLD	($000) Dollars	Dollars/ WKLD	FTEE	FTEE/(000) WKLD
In-patients treated	1,339,270	$5,876,544	$4,388	155,293	116
Outpatient visits(000)	19,586	$1,686,184	$ 86	32,551	1.7
(Staff and Fee)					

B. The ratios (i) between the amount originally available ($9.248 billion plus any amount carried over from FY 1985) in FY 86 and the estimated numbers of inpatients and outpatient visits in FY 1986, and (ii) between the number of FTEE planned to be employed using that amount and the estimated numbers of inpatients and outpatient visits in FY 1986.

Answer: The ratios for 1986 ($9.248 billion plus carryover from FY 1985) are provided below:

		(i)		(ii)	
		($000)	Dollars/		FTEE/(000)
VA Facilities	WKLD	Dollars	WKLD	FTEE	WKLD
In-patients treated	1,340,270	$6,122,126	$4,568	155,964	116
Outpatient visits(000)	19,678	$1,796,898	$ 91	32,582	1.7
(Staff and Fee)					

C. The ratios (i) between the amount available in FY 86 after sequestration and the estimated number of inpatients and outpatient visits in FY 1986, and (ii) between the number of FTEE planned to be employed using that amount and the estimated numbers of inpatients and outpatient visits in FY 1986.

Answer: The ratios for FY 1986 (post-sequestration) are provided below:

		(i)		(ii)	
		($000)	Dollars/		FTEE/(000)
VA Facilities	WKLD	Dollars	WKLD	FTEE	WKLD
In-patients treated	1,340,532	$6,044,224	$4,509	155,007	116
Outpatient visits(000)	19,678	$1,776,025	$ 90	32,333	1.6
(Staff and Fee)					

E. The ratios (i) between the amount requested for FY 1987 and the estimated numbers of inpatients and outpatient visis, and (ii) between the number of FTEE planned to be employed and the estimated numbers of inpatients and outpatient visits.

Answer: The ratios for FY 1987 follow:

		(i)		(ii)	
		($000)	Dollars/		FTEE/(000)
VA Facilities	WKLD	Dollars	WKLD	FTEE	WKLD
In-patients treated	1,283,327	$5,953,982	$4,639	149,395	116
Outpatient visits(000)	18,564	$1,739,317	$ 94	30,362	1.6
(Staff and Fee)					

Question: 4. The Administration does not plan to submit a supplemental appropriations request for any increased VA employee pay costs (not provided for in the FY 1986 budget request). What amounts for such costs (and for what items) is the VA being required to absorb in each of the following accounts: Medical care, medical and prosthetic research, medical administration and miscellaneous operating expenses, general operating expenses, and construction, minor projects?

Answer: Pay costs are not being absorbed in 1986. The major items of payroll cost have not increased. Federal employees did not receive a pay raise in 1986 and the government's portion of Federal Employees Health Benefits decreased. Therefore, 1986 supplementals for increased pay costs were not generally necessary. In the MAMOE appropriation, the 1986 estimated average salary exceeds the budgeted level and a need for $1,016,000 to support average salary was identified. Estimated average employment (FTEE) was reduced by 23 to absorb this requirement.

Question: 5.A. With regard to the "one percent productivity increase" discussed on pages 5-16 of the V.A. budget documents, please provide as much detail as is available at this time regarding the nature of the actions that will increase productivity and how they will be translated into personnel reductions and indicate, by facility and occupation, from which facilities the 1,939 FTEE reduction will be taken.

Answer: As part of the Government-wide initiative to increase productivity, the Department of Medicine and Surgery will reduce staffing levels across the board by 1% in Fiscal Year 1987. In preparation for the Fiscal Year 1987 Target Allowance distribution process, it is planned that these reductions in staffing levels will be primarily in "indirect" or non-patient care, i.e., administrative, building management, and engineering, etc. It will be at the Medical Center Director's discretion as to how the assigned "one percent productivity" FTEE reductions will be translated into the specific types of occupations to be reduced.

Question 5.B. Please also describe the actions taken to achieve a similar "one percent productivity increase" for FY 1986 and the outcome to date of those efforts.

Answer: As part of the Government-wide initiative to pursue productivity, a 1% across the board reduction in employment levels was implemented in the FY 1986 Target Allowance distribution process. This provided a reduction of $52,367,000 and 1,916 FTEE. This 1% productivity reduction was applied against each V.A. Medical Center's "indirect" or non-patient care areas, i.e., administrative, building management, engineering, etc. The specific positions relative to the indirect FTEE reductions were selected at the discretion of the V.A. Medical Center Director. However, the impact of this dollar and FTEE reduction on the VAMCs was somewhat lessened when Congress added the 1,893 FTEE and allowed a carryover of resources into 1986 of the 1985 supplemental ($55,272,000).

Question: 6 A. Please indicate what resources, both in terms of FTEE and dollars, DM&S devoted in FY 1985 and plans to devote in each of FYs 1986 and 1987, to the following activities:

(i) Hospital-based home care (HBHC) programs.
(ii) Geriatric Research, Education and Clinical Centers.
(iii) Geriatric evaluation units (GEUs).
(iv) Adult day health care (ADHC) services (in total and with a breakdown for VA in-house and contract).
(v) Hospice programs.
(vi) Programs to coordinate VA programs with appropriate community programs.

Answer: Resources (dollars in thousands)

		1985		1986		1987	
		BA	FTEE	BA	FTEE	BA	FTEE
(i)	HBHC	$15,306	412	$16,094	421	$17,382	442
(ii)	GRECC	$ 9,919	217	$ 9,272	198	$ 9,310	197
(iii)	GEU 1/	$ 1,400	34	$ 1,400	34	$ 1,400	34
(iv)	ADHC	$ 1,324	34	$ 1,324	34	$ 6,424	59
	VA	($ 1,324)	(34)	($ 1,324)	(34)	($ 1,324)	(34)
	CONTRACT					($ 4,000)	
	RESEARCH					($ 1,100)	(25)
(v)	HOSPICE 2/						
(vi)	COORDINATION 3/						

1/ 1985 Congressional add-on (resources shown in chart) provided enhancement of 17 GEUs previously established from VAMC's operating funds. There were 45 GEUs operational in 1985. A cost distribution system has not been established to specifically track the cost of GEUs.

2/ A cost distribution system has not been established to track the Hospice program.

3/ DM&S does not track resources specific to the coordination of VA programs with the community. Coordination is part of the regular duties of assigned personnel in some clinical services in the VAMCs, such as social workers.

Question: 6 B. What efforts are ongoing or planned for FY 1986 or 1987 to evaluate the cost-effectiveness of HBHC programs, GEUs, ADHC programs, respite care, and any other programs designed to meet the needs of older veterans in non-institutional settings?

Answer: On July 9, 1985, the VA submitted a report to the Office of Management and Budget on the cost-effectiveness of "Substitutes for Long Term Institutional Care." As requested, the report addressed Hospital Based Home Care (HBHC), Adult Day Health Care (ADHC), Geriatric Evaluation Units (GEUs) and Geriatric Research Education and Clinical Centers (GRECCs). While HBHC and ADHC are "true" non-institutional long term care alternatives, it was pointed out that GEUs are special intensive programs for comprehensive assessment of an elderly veteran's complex needs, and GRECCs are unique centers of excellence in the development and dissemination of new knowledge in the care of the elderly. The "Summary and Conclusion" was that "In general, it can be concluded for each of the four programs that there is considerable evidence for their cost-effectiveness... In summary, while the cost-effectiveness of these four programs is being questioned, one should not lose sight of the many other attributes which make them exquisitely relevant to providing for a rapidly aging veteran population. Also, these particular programs have been recognized in many quarters as typical of the progressive leadership demonstrated by the VA in facing the geriatric imperative." The report is attached.

COST-EFFECTIVENESS OF HBHC

A research project is presently being conducted at the VA Medical Center Hines, Illinois, to answer the following major questions:

1. Is the ADL functioning of patients who receive hospital based home care maintained as well as those patients randomized to the control group who receive customary care?
2. Do severely disabled and terminally ill patients who receive hospital based home care experience fewer institutional (hospital and nursing home) stays than severely disabled and terminally ill patients who receive customary prevailing care (discharge to a caregiver or to a nursing home)?
3. Is the morale of patients who receive hospital based home care as high or higher when compared to the randomized controls who receive customary care?
4. Is the total cost of care for severely disabled and terminally ill patients who receive hospital based home care lower than for severely disabled and terminally ill patients who receive customary prevailing care?

Using a randomized controlled trial for the study design, consecutive admissions to the oncology and neurology in-patient services are being screened for a period of one year. Funding was provided for this three year project in FY 1984 by the VA's Health Services Research & Development Service. The final report is not expected until 1987.

COST-EFFECTIVENESS OF ADHC

The VA has conducted pilot studies and developed a protocol to conduct an evaluation of adult day health care compared to VA nursing home care as mandated by P.L. 98-160. The study is expected to be implemented in FY 1987 with resources requested in the budget. Preliminary data are expected to be available in FY 1989.

COST-EFFECTIVENESS OF GEUs

A major investigation of the effectiveness of Geriatric Evaluation Units (GEU's) has already been conducted at the Geriatric Research, Education and Clinical Center (GRECC) in Sepulveda, CA. This research, which was funded by the VA Health Services Research & Development Service, has reported the following results in the New England Journal of Medicine (Rubenstein, et al. 1984) and the Journal of the American Geriatrics Society (Rubenstein, et al. 1984): patients assigned to the GEU had significantly lower mortality than controls, were less likely to have initially been discharged to a nursing home or to have spent any time in a nursing home, had substantially fewer acute-care hospital re-admissions and hospital days, and were significantly more likely to have improvement in functional status and morale. Direct costs for institutional care were found to be significantly lower for the GEU group, particularly after adjustment for survival.

Currently there is no centrally directed research on the cost-effectiveness of GEUs planned in FY 1986 or 1987. There are, however, a number of on-going investigator initiated research projects related to this program area, some of which are supported by non-VA funds:

Beeker, P., M.D. GRECC, Durham VAMC
Impact of a Geriatric Consultation Team in an Acute
Care Hospital

Brook, R., M.D. GRECC, W. Los Angeles VAMC
Toward Rational Reduction in the Use of Medical Services

Nobel, J., M.D. & Rubenstein, L., M.D. GRECC, Sepulveda VAMC
Effectiveness of Boston City Hospital GEU

Moss, R. H., Ph.D. Palo Alto VAMC
Evaluating Sheltered Care Settings for Older People

Reaven, G. M., M.D. GRECC, Palo Alto VAMC
Multidisciplinary Study of Geriatric Chronic Health Care

Rubenstein, L. Z., M.D., et al. GRECC, Sepulveda VAMC
Assessing the Effectiveness of an Inpatient Geriatric
Evaluation Unit

Winograd, C. H., M.D. GRECC, Palo Alto VAMC
An Analysis of an Acute Geriatric Evaluation Service

COST-EFFECTIVENESS OF RESPITE CARE

The VA does not have specific authority to furnish respite care. We therefore do not have plans to evaluate respite care at this time.

WHITE PAPER

"Substitutes for Long Term Institutional Care"

OMB request, February 14, 1985:

"Several alternatives and supplements to institutional care, including Hospital Based Home Care, Adult Day Health Care, Geriatric Evaluation Units and GRECCs have been implemented in, or considered by your Agency in recent years. OMB is interested in an evaluation of the cost-effectiveness of each of these alternatives as substitutes for institutional care. VA should provide a report to OMB by March 15, 1985, of any completed and on-going evaluations of these activities and specific recommendations for additional efforts necessary to fully evaluate the cost-effectiveness of these alternatives."

This report was prepared with the assistance of Mr. Robert W. Abel, Dr. Eliza Wolff, Dr. David Fago, Dr. James Pozard, Mr. J. R. Kelly, Mr. Daniel Schoeps, Ms. Yasuko Shiraishi, and Mr. Thomas Tillman.

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Contact Point:

John H. Mather, M.D.
Office of Geriatrics and Extended Care (18)
Tel. 389-3781

Substitutes for Long Term Institutional Care

INTRODUCTION

The continuing assessment of the efficiency and effectiveness of programs provides a sound basis for formative evaluations and, with sufficient time and experience, establishes their "value" as a summative evaluation. The assessment of any program's efficient operation and efficacy in achieving certain purposes is difficult at best and even more so when it is a medical or health program.

Usually the evaluation is related to the resources expended in developing and maintaining a specific program. Several terms are then posed as determining the "value" and "costs" of the programs, such as opportunity-costs, cost-savings, cost-avoidance, cost-benefits, and cost-effectiveness. The terms related to developing or deciding not to continue existing programs are opportunity-costs, cost-savings, and cost-avoidance. These are not the areas of direct relevance to this inquiry although they are terms of adjunct commentary.

Cost Analyses

The terms of inquiry directly relevant are cost-benefit or cost-efficiency analysis, and cost-effectiveness analysis. Cost-benefit or cost-efficiency analysis is very important in assessing the utility of various medical and health programs. It can be crudely described as determining whether funds expended are achieving maximum productivity of providers to the greatest number of recipients while maintaining an optimum quality of care. Although this inquiry is primarily concerned with cost-effectiveness, the cost benefits or cost-efficiencies cannot be ignored. Wherever appropriate, such considerations relevant to comments on cost-effectiveness are discussed.

Within this report, the following definitions are used: 1/

Cost-Benefit Analysis (Cost-Efficiency): A study primarily concerned with economic efficiency; the consideration of whether total benefits outweigh the total cost of providing them.

Cost-Effectiveness Analysis: A study concerned with technological efficiency and comparison of alternative approaches or projects in a program area.

A convenient schematic comparison, although somewhat over simplified, is displayed in the following table:

COMPARISON OF TWO ECONOMIC ANALYSIS APPROACHES 1/

	Cost-Benefit	Cost-Effectiveness
Geared to	Economic efficiency	Technological efficiency
Measurment units	Dollars	Various measures
Variable components	Costs and benefits	Costs, with benefits fixed; benefits, with cost fixed
Main question	Whether the program is justified	How resources should be used in a program
Scope	Global, comprehensive	Narrow, focused
Usual application	Capital projects	Ongoing operating programs
Time-frame	Long-term	Short-term

These analyses in the medical and health field are the general province of health services research or, more broadly, operations research. The classic methods of analysis in both kinds of research are very time consuming and require considerable expenditures to reach definitive conclusions. This is by no means a defense for no research at all but rather a challenge to provide additional

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1/McKenna, Christopher K, Ph.D. Quantitative Methods for Public Decision Making. McGraw Hill:New York, 1980.

funds to take the current findings to greater levels of validity and reliability.

Cost-Effectiveness of Medical and Health Programs

The cost-effectiveness studies in the provision of health services have generally focused on acute care modalities and technologies. Even these studies have had their difficulties with determining the appropriate methods, investigative approach and analysis of results. 2/

In the area of long-term care and geriatrics, there are particular added complications associated with cost-effectiveness research. By definition those receiving long-term care have one or more chronic medical and health conditions that necessitate continuing care from one or more providers. Care is not episodic but continuous and the desirable end points depend in great measure on the fluctuations in the chronic medical and health problems with intercurrent acute episodes. Also, the impaired socio-economic status of the recipient of long term care often compromises the ability to conduct rigorous "uncontaminated" research.

The quantitative techniques that make comparisons and draw distinctions between various medical and health services have great utility. They may also be useful in guiding the allocation of health care resources. Unfortunately, these techniques have major shortcomings when applied to high risk populations such as the elderly. These analyses are particularly insidious and pervasive with a "virtual guarantee (of) an anti-geriatric bias." 3/

2/Moses, Lincoln E: Statistics in Practice: Statistical Concepts Fundamental to Investigations. The New England Journal of Medicine, pp 1890-897, April 4, 1985.

3/Avon, Jerry: Benefit and Cost Analysis in Geriatric Care: Turning Age Discrimination into Health Policy. The New England Journal of Medicine, pp 1294-1301, May 17, 1984.

The Scope of the Papers

Notwithstanding these caveats, the following papers provide a compelling account of the cost-effectiveness of these various program. The variety extends from Hospital Based Home Care and Adult Day Health Care as "true" non-institutional long term care alternatives, to Geriatric Evaluation Units as special intense programs for comprehensive assessment of an elderly veteran's complex needs, and Geriatric Research, Education, and Clinical Centers as unique centers of excellence in the development and dissemination of new knowledge in the care of the elderly.

Each paper approaches the subject under the following headings:

- Program Nature and Scope
- Studies of the program
- Studies of the VA's program
- General Summary and Conclusions of Evaluative Studies on the VA program

Summary and Conclusion

In general, it can be concluded for each of the four programs that there is considerable evidence for their cost-effectiveness. While work will continue on assessing the value of these programs, it cannot progress for Adult Day Health Care without the establishment of more VA operated programs and development of a contract program. The continued development of an overall evaluation strategy for the GRECC Program will, during the coming year, provide a useful systematic methodology.

In summary, while the cost-effectiveness of these four programs is being questioned, one should not lose sight of the many other attributes which make them exquisitely relevant to providing for a rapidly aging veteran population. Also, these particular programs have been recognized in many quarters as typical of the progressive leadership demonstrated by the VA in facing the "geriatric imperative."

HOSPITAL BASED HOME CARE (HBHC)

Program Nature and Scope.

The Hospital Based Home Care (HBHC) Program, at 49 VA medical centers, provides chronically ill veterans with primary health care services in their own homes. A treatment team consisting of a physician, registered nurses, home health aides, social worker, clinical dietitian, and rehabilitation therapists provide primary care in the home and train family members in the ongoing care of the patient. In FY 1984, 199,759 home visits were made by health professionals and 9,851 patients were treated.

It is essential to point out that there are substantial differences between in-home services, home health or home care services, and hospital based or hospital administered home care services. In-home services are limited to the homemaker and/or home health aide level of health services and are funded primarily through Title XX of the Social Security Act and Title IIIB of the Older Americans Act. Home health or home care services are reimbursed by Medicare, either Part A or Part B of Title XIX of the Social Security Act, and to qualify the beneficiary must be homebound and certified by a physician to be in need of skilled nursing and one other service; physical, speech, or occupational therapy services ("skilled plus one rule"). Once the beneficiary qualifies, other home health benefits specified by law may be added, e.g., medical and social services, medical supplies, medical equipment, and the intermittent services of a home health aide. The patient's physician is responsible for establishing and periodically reviewing the plan of care, but rarely is involved in providing services. Prior to July 1, 1981, Part A further stipulated that the beneficiary must have been hospitalized for 3 days for the condition for which the home health service was ordered and limited to 100 the number of home visits reimbursable. Most of the Blue Cross and other health insurance plans follow the Medicare plan of reimbursable services. Hospital based or hospital administered home care programs usually furnish the same array of services (because of Medicare or other health insurance plans) but focus upon the coordination of services as many hospitals contract for some services, usually skilled nursing care and home health aides. Also, hospital based home care programs usually are premised upon providing follow-up care to a hospital episode of illness.

Studies of Home Health Care

Studies on the cost effectiveness of home care services may be categorized in five topical headings: (1) earlier hospital discharge; (2) prevention of hospitalization; (3) prevention of nursing home placement; (4) effectiveness of home care services as part of an array of community based programs; and (5) the impact of home care services upon the total cost of health care.

Early studies of home care services (1960s) were based on the concept of earlier hospital discharges.1,2,3/ Rawlinson reports that Blue Cross of Philadelphia saved an average of 12.9 days of hospitalization and $330 per patient of hospital costs through the furnishing of home health services over an eleven year period of time. Fifty-one percent of the patients were under the age of 65. The average length of home care stay was 31 days, the median 24 days. The focus of the program is on short term home care following an episode of acute care in

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1/Stiefel, J.B: Use and Cost of AHS Coordinated Home Care Programs. Inquiry, Vol. IV, No. 3, Oct. 1967.

2/Stone, J., et al: The Effectiveness of Home Care for General Hospital Patients. JAMA, July 15, 1968.

3/Rawlinson, H. Coordinated Home Care: An Effective Alternative in Home Health Services in the United States. In: A Report to the Special Committee on Aging. U.S. Senate, Washington, D.C., April 1972.

the hospital and is described in the literature as "intensive level of care."[4/] The Blue Cross of Philadelphia studies on earlier hospital discharges largely formed the theoretical framework for the Medicare home care legislation (P.L. 89-97) and explains the bias toward short term home care as a function of post hospital care. The studies on the concept of earlier hospital discharges are characterized by a lack of scientific rigor. Because existing data for program operation were utilized (contrasted with the collection of specific data designed to answer carefully constructed questions) the patient population, along with the intensity and complexity of services furnished, are not defined. Findings are usually presented in hospital days saved and in dollar amounts saved. These figures are typically determined by a registered nurse and physician estimating the number of days the patient would have remained in the hospital had home care services not been available. Kurowski, et al [5/] notes that, however well intentioned, these studies have probably served as an impediment to the growth of home care programs. Two studies [6,7/] have addressed the question of "administratively necessary days" (AND) of elderly, chronically ill patients remaining in the hospital while awaiting the establishment of Medicaid eligibility or awaiting a nursing home bed. Tolkoff-Rubin, et al, report that the Massachusetts General Hospital has been able to discharge AND patients through their own home care program. The average waiting period was 14 days. Costs are compared be-

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[4/] American Hospital Association. Assembly of Ambulatory and Home Care Services: A Prospectus for a National Home Care Policy. Chicago, Illinois, 1978.

[5/] Kurowski, B.: Cost Per Episode of Home Health Care. Center for Health Services Research, University of Colorado Medical Center, Denver, Colorado, March 1979.

[6/] Eggert, G.M., Brodows, B.: Five Years of ACCESS: What Have We Learned? Home Health Care Services Quarterly, Vol. 4, Nos. 3-4, 1983.

[7/] Tolkoff-Rubin, et al: Coordinated Home Care - the Massachusetts General Hospital Experience. Medical Care, Vol. XVI, No. 6, June 1978.

tween home care and maintenance in a skilled nursing home. The home care program coverage averaged $585 per month. If this amount is added to the average cost for room and board in Boston as determined by the Bureau of Labor Statistics, the comparable total cost would be $810 per month. Costs in a skilled nursing home averaged $35 per day, and with the additional costs of physician care, adjunct services, medications, and medical equipment, totaled $1,500 per month.

Literature on the comparative costs of placement in a nursing home compared with home care services was published primarily in the 1970s when alternatives to institutionalization became the focus of attention following the 1970 White House Conference on Aging. These studies 8,9/ are characterized by an improvement by the usage of validated study instruments which were emerging from health service researchers. Utilization of the activities of daily living (ADL) instrument as developed by Katz 10/ and the OARS instrument 11/ to define comparability in and between patient groups became the hallmark of these studies. Three studies address the question of level and intensity of home care services and costs compared with nursing home care. In a study conducted of their home care program, St. Vincent's Hospital in New York City 12/ found that the ambu-

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8/Greenberg, J.: The Costs of In Home Services. In: A planning study of services to non-institutionalized older persons in Minnesota. University of Minnesota, School of Public Affairs, Minneapolis, Minnesota, 1974.

9/Applebaum, R, et al: The Wisconsin Community Care Organizations: Preliminary Findings from the Milwaukee Experiment. The Gerontologist, Vol. 20, No. 3, June 1980.

10/Katz, S., et al: A Measure of Primary Sociobiologic Functions. International Journal of Health Services, Vol. 6, No. 3, 1976.

11/Multidimensional Functional Assessment: The OARS Methodology Center for the Study of Aging and Human Development. Duke University, Durham, North Carolina.

12/Scharer, L.K., Boehringer, J.R.: Home Health Care for the Aged: The Program of St. Vincent's Hospital, New York City. The Florence V. Burden Foundation, New York, New York, 1976.

latory patient in a nursing home subsidizes the bedbound patient. The costs for nursing home care may be greater or less than those for home care depending upon the patient's service need. The study concluded that for equal levels of need, the cost of home care is less than that of nursing home care. The study, however, does not distinguish between intermediate and skilled nursing facilities. The study by Kurowski, et al 13/ indicates that the cost of home care is related to the level of the patient's disability. They conclude that greater improvement in functional status can be attained when higher costs are incurred. Stroke patients receiving rehabilitation care are generally more costly than other types of patients. The average cost for patients who died in their home was the highest of any patient group. The findings suggest that the patterns of home care practice for the terminally ill are difficult to explain and that it may be even more difficult to predict the costs for this group of patients. In a study conducted by the General Accounting Office (GAO) 14/ the methodology focused upon determining the break-even point between the costs of home care and those of nursing home care. Their study indicates that for a patient who is greatly impaired (the OARS instrument was used), the cost of home care exceeds the cost of caring for that patient in a nursing home. The GAO methodology has recently been challenged by Thomas Willemain 15/ for internal inconsistencies in establishing the break-even point.

Home care studies of the 1980s address the questions of the effectiveness of a single entry access point ("gatekeeping") to the health delivery system to test

13/Ibid.

14/United States Comptroller General, General Accounting Office: Home Health--the Need for a National Policy to Better Provide for the Elderly. Washington, D.C., Dec. 1977.

15/Willemain, T.R.: Beyond the GAO Cleveland Study: Client Selection for Home Care Services. Home Health Care Quarterly, Vol. 1, No. 3, 1980.

the concept of service coordination by a case manager. One such study, TRIAGE,16/ conducted in a seven town area of central Connecticut, provided the conceptual framework for the Department of Health and Human Services' National Long-Term Care Demonstration. Home care studies of the 80s almost uniformly utilize the Katz Index of ADL Instrument, the Lawton/Brody Instrumental Activities of Daily Living instrument, and the Mental Status Questionnaire of Kahn, et al. The most recently published study on home care cost effectiveness was reported by Zimmer, et al 17/. The study was designed to randomly assign patients after screening and stratification to an interdisciplinary home care team (experimental) or to a control group. The study findings show that the experimental group had fewer hospitalizations, nursing home admissions, and outpatient visits than did the control group. The average cost per day in the experimental group was 8.6% lower (not statistically significant) than in the control group.

General Summary & Conclusions of the Literature Review

During the past ten years a number of research studies on home health services have been funded as demonstration projects by the Health Care Financing Administration, Department of Health and Human Services. Many of these studies have yielded inconsistent results with respect to outcomes and costs. Most of the studies are characterized in study design by the lack of suitable control groups. Group similarity at the time of program enrollment is highly questionable in many of the studies. Another serious problem is the absence of a parallel cost accounting system for home health care and institutional care. Home health costs are expressed as an average cost per visit or as an average daily cost per patient. Additionally, as these studies are of Medicare reimbursed

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16/Hicks, B., et al: The TRIAGE Experiment in Coordinated Care for the Elderly. American Journal of Public Health, Vol. 71, No. 9, Sept. 1981.

17/Zimmer, et al: A Randomized Controlled Study of a Home Health Care Team. American Journal of Public Health, Vol. 15, No. 2, Feb. 1985.

agencies, the restrictions of that program limit the universality of the study findings. It should be pointed out that Medicare reimbursement is based on home care agency charges, not costs. The costs cited in these studies are, therefore, charges. Of particular interest to the Veterans Administration is the overwhelming female population in these studies and in the Medicare Home Health Care Program in general. Also, these studies are predominantly of community home health agencies which are characterized by less than optimal physician involvement in the quantity and quality of the health services delivered. With the required physician participation in hospice home care, perhaps the situation will change for the general medical home health programs.

Studies of the VA's Hospital Based Home Care Program (HBHC)

Two studies have been completed on the organization and administration of HBHC. The first report was issued by GAO in 1981. 18/ Five recommendations made to the Chief Medical Director as a result of this study were as follows:

1. Clearly define the objectives of the VA's home care program, emphasizing the cost benefits as a primary goal, and convey the objectives to all medical centers.
2. Develop guidelines that assure more uniformity and consistency among the medical centers' home care programs.
3. Conduct periodic program evaluations to assure that individual home care programs are carried out in accordance with agency policy and program objectives.
4. Identify the number of veterans in VA medical facilities who are suitable for home care placement.
5. Provide the program with adequate funding so that it can be expanded.

18/United States Comptroller General, General Accounting Office: VA's Home Care Program is a cost-beneficial alternative to institutional care and should be expanded, but program management needs improvement. Washington, D.C., April 1981.

The second report, by the VA's Office of Program Planning and Evaluation 19/ was issued in 1983, pursuant to 38 U.S.C., Section 219. The evaluation's most significant findings and conclusions are summarized below:

1. Quality assurance plays an important role in each local HBHC Program. Joint Commission on Accreditation of Hospitals (JCAH) standards guided Central Office managers in establishing program operating procedures. Each local program has its own quality assurance program based on these guidelines.
2. To keep abreast of patients' evolving needs, HBHC teams conduct reviews of patients' treatment plans every 60 days.
3. Factors influencing HBHC costs are types of patients (patient mix), local program staffing levels and mix, local fiscal accounting practices, and variations in the cost associated with running an urban versus a rural HBHC Program.
4. If future cost studies of VA's HBHC Program uphold the premise that home care services are a significantly cost efficient alternative to inpatient care, the Department of Medicine and Surgery should determine the number of patients suitable for HBHC placement VA-wide. Resources should then be allocated to expand VA home care services according to projected needs.

The recommendations made by the GAO have been implemented with the publication of the manual, M-1, Part I, Chapter 30, "Home Health Services," and have been incorporated into program operations. The recommendations of the Office of Planning and Evaluation have also been completed. Detailed instructions have been published for the fiscal service for more uniformity in accounting and

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19/Veterans Administration, Office of Program Planning and Evaluation: Hospital Based Home Care Program Evaluation. Washington, D.C., July 1983.

reporting practice. Studies have been undertaken to more precisely define the program costs associated with the types of patients and the staffing levels and mix.

In 1980, the ACMD for Geriatrics and Extended Care conducted an evaluation of HBHC in response to a request from the Senate Appropriations Subcommittee. 20/ Ten HBHC sites selected for geographic distribution and program characteristics participated. A total of 912 patients were included in the study. The average age of all patients treated during the study was 68 years, 98% were male, and 94% had multiple active diagnoses. The average utilization rate of medications was 7.5 prescriptions. Utilization of prosthetics and durable equipment averaged 3 items per patient. Of all patients treated 48.5% represented the VA's top three eligibility priorities for outpatient care. VA medical center hospitals accounted for 79% of the referrals of all patients treated during the study period. Of the patients discharged from HBHC during the study period, 53% required hospital care, 16% had achieved their treatment goals, and 12% died at home. In 7% of the discharges, the caregiver in the home was unable to continue providing care to the patient, and 5% of the patients were discharged to be treated as outpatients.

In an unpublished paper, Lutgen 21/ reports on a study of an interdisciplinary HBHC Program at the VA Medical Center Madison, Wisconsin. Service disciplines on the team included medicine, professional nursing, physical therapy, occupational therapy, clinical dietetics, social worker, and clinical pharmacy. The experimental group consisted of 22 patients in HBHC over 60 years of age with

20/Veterans Administration, Department of Medicine & Surgery: Services and costs of the VA Hospital Based Home Care Program. Washington, D.C., Feb 1980.

21/Lutgen, T.A.: Home Health Care as a Successful Form of Cost Containment. A study of the geriatrics health outreach program. Madison, Wisconsin, November 1979.

the following chronic diseases: chronic obstructive pulmonary disease, congestive heart failure, malignant neoplasm, and chronic alcoholism. The control group, representing similar characteristics, was randomly selected from patients in the hospital and compared for inpatient days of care. The results show that the experimental group (home care) had an aggregate total of 460 inpatient days or an average of 20.9 patient days, and the control group (hospital bed patients) had an aggregate total of 1,466 inpatient days or an average of 66.6 patient days during the specified time period. The experimental group had 1,006 less inpatient days than the control group or a savings of 69% patient days.

In a 1981 study conducted by Karklins 22/ of an evaluation of the VA's pilot Rural HBHC Program in the State of Arkansas, which is described as an area with a paucity of health care resources, veterans have necessarily become dependent on the VA for much or all of their health care needs, including primary care. Thus, when the need for long term care arises, if home care is to be offered as an alternative, the realistic option is to offer a home care model which provides primary care. Rural home care, which operates as a satellite of the HBHC Program at the Little Rock VAMC, is supported by the skills and knowledge of that hospital. In comparing the costs between the rural satellite and urban hospital based programs, costs for direct primary care, medications, and the support services of the hospital (laboratory, radiology, and specialty outpatient clinics) accounted for only 24% of the total program costs in both the rural and urban programs; provider time in travel and direct transportation costs for home visits represented 8% and 9.2% for the rural and urban programs respectively. The majority of the program costs were attributable to management and administrative categories for both programs: case management (36% rural, 38% urban),

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22/Karklins, J.: An Evaluation of the Veterans Administration's Pilot Rural Hospital Based Home Care Program. Little Rock, Arkansas, May 1981.

program administration (6% rural, 5% urban), and clerical support (9% rural and 6% urban). This study's findings support the concept of program efficiency and cost effectiveness through a centralized management of a consortium of hospital home care programs applied in a rural program managed from a hospital administered home care program.

The 1984 evaluation report of HBHC was a collaborative effort between the Administration on Aging (AoA) and the Office of Geriatrics and Extended Care. 23/ An interagency agreement with AoA supported the contracted data analysis. Of the 1,659 patients admitted to HBHC, a patient profile emerges of the typical patient who can be described as 67 years old, married (69%), with an elderly spouse serving as the caregiver. A significant fraction, 32%, of the caregivers were judged by staff to have moderate or moderately severe limitations. Thirty percent of the HBHC patients have significant visual impairments and 25% have hearing impairments. Almost half of the patients require some help in walking, and 16% are bedbound. While over half require assistance in bathing and dressing, less than half require assistance in using the toilet, transferring, and in feeding themselves. Twenty-five percent of the patients were incontinent or required management by others of devices for incontinence. Of the services provided in the home by the HBHC team, 57% were provided by professional nurses, 10% by social workers, 9% by home health aides, 6% by physicians, 7% by clinical dietitians, 6% by rehabilitation therapists, and 3% mental health services. HBHC support services utilized were laboratory procedures, 39%; radiology, 1%; pharmacy, 50%; clinical pharmacist consultation, 4%; and medical specialty consultations/referrals, 2%. HBHC services to the caregiver included emotional

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23/Veterans Administration, Department of Medicine & Surgery: The Veterans Administration's Hospital Based Home Care Program: Patients, use, services, costs. Washington, D.C., April 1984.

support, 44%; supervision/evaluation of patient care, 32%; psycho-social counseling, 5%; terminal care counseling, 2%; and bereavement counseling, 2%. The time spent on each patient visit varied according to the patients' diagnosis and averaged 40 minutes for all visits. Home visits by provider were distributed as follows: registered nurse, 38%; licensed practical nurse, 30%; social worker, 11%; therapist, 10%; physician, 6%; clinical dietitian, 4%. Cost data were collected in identified categories specific to HBHC and the categorical costs as a percent of the total cost of HBHC were calculated as follows: direct patient care (15.9%); services and procedures (.8%); medications and disposal medical supplies (9.4%); durable medical equipment and oxygen (.5%); specialty clinics (5.4%); case management (36.5%); provider time in travel (6.3%); provider mileage costs (3.3%); clerical support (4.7%); and hospital support (17.2%). Average costs for HBHC were determined to be $59.48 per visit, $13.96 per patient day, and $1,449.08 per patient treated.

Evaluation and research studies about VA HBHC published in professional journals include the following authors: Haber, Mitchell, Inui, et al, Rodell and Jameson, and Jameson, et al. Haber's 24/ study examines the medical benefits of HBHC after myocardial infarction and the attenuated cost savings.

One research study has been completed of the VA's HBHC Program. In 1978, Mitchell 25/ evaluated 318 patients for functional status in three different VA placement settings: VA nursing home care unit, VA community contract nursing homes, and hospital based home care. Three months later, patients were reevaluated for functional status. Patients placed in HBHC showed significantly greater

24/Haber, P.A.: Hospital Based Home Care After Myocardial Infarction. Geriatrics, Vol. 30, 1975.

25/Mitchell, J.B.: Patient Outcomes in Alternative Long-Term Care Settings. Medical Care, Vol. XVI, No. 6, June 1978.

mean improvement than did patients in the two nursing home care programs. HBHC was also the most successful in ability to retain patients in their program.

Inui, et al 26/ devised a nurse screening methodology of patient discharges to estimate need for HBHC services. In the hospital study an estimated 64% of discharged patients appropriate for HBHC did not receive these services.

Rodell and Jameson 27/ examined 116 patients assigned on the basis of geographical location to an urban or rural HBHC to test the significance of program differences measured on medical and socio-economic patient characteristics of a chronically ill population. Using a two-tailed difference of group means t-tests, the data revealed that only the number of medications and disposable medical supplies dispensed were significant.

Jameson, et al 28/ describe a three stage evaluation and research plan for HBHC: (1) description of program using an automated information system to describe the patients served and services provided; (2) program evaluation to determine "are we doing what we say we are doing?"; and (3) experimental research to test the cost effectiveness of HBHC compared to alternative treatment modalities.

A research project is presently underway at VA Medical Center Hines, Illinois, to answer the following major questions:

1. Is the ADL functioning of patients who receive hospital based

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26/Inui, T.S., et al: Needs Assessment for Hospital Based Home Care Services. Research in Nursing and Health, Vol. 3, 1980.

27/Rodell, D.E., Jameson, J.H.: Similarities and Differences between an Urban and a Rural Hospital Based Home Care Program. Home Health Care Services Quarterly, Vol. 2, No. 4, 1981.

28/Jameson, J.H., et al: A Program of Evaluation and Research for Hospital Based Home Care. Home Health Services Quarterly, Vol. 4, No. 1, 1983.

home care maintained as well as those patients randomized to the control group who receive customary care?

2. Do severely disabled and terminally ill patients who receive hospital based home care experience fewer institutional (hospital and nursing home) admissions and experience shorter institutional (hospital and nursing home) stays than the severely disabled and terminally ill patients who receive customary prevailing care (discharge to a caregiver or to a nursing home)?
3. Is the morale of patients who receive hospital based home care as high or higher when compared to the randomized controls who receive customary care?
4. Is the total cost of care for severely disabled and terminally ill patients who receive hospital based home care lower than for severely disabled and terminally ill patients who receive customary prevailing care?

Using a randomized controlled trial for the study design, consecutive admissions to the oncology and neurology inpatient services are being screened for a period of one year. Funding was provided for this three year project in FY 1984 by the VA's Health Services Research & Development Service. While preliminary data will be available as early as the end of 1985, the final report is not expected until 1987. Although this is the first randomized clinical trail of the VA's Hospital Based Home Care Program, the generalizability to the entire system is limited. Selecting two diagnostic categories to be studied will describe only a small segment of the hospital based home care patient population served systemwide. Additional efforts are necessary but will require additional resources to fully evaluate the cost effectiveness of hospital based home care.

General Summary and Conclusions of Evaluative Studies on VA HBHC

The VA's findings in the evaluation of the effectiveness and costs of HBHC over the years shows that long term home care can be efficiently furnished to chronically ill patients through an interdisciplinary team in a quality manner. The inpatient hospital days saved by serving the patient at home assists in freeing these beds and averts administratively necessary days in the busy teaching hospitals where HBHC is located.

The Health Services Research and Development Service (HSR&D) recently received a research proposal to develop and test a patient related Chronic Care Case Mix (CCCM) for HBHC patients. This case mix tool will have clinical application for more precisely defining prospectively the level and intensity of HBHC services necessary to support the patient at home and the resources required to support those services. This three year research proposal, presently being reviewed for scientific merit and relevancy, would commence in Fiscal Year 1986 if funded.

ADULT DAY HEALTH CARE (ADHC)

Program Nature and Scope

The Adult Day Health Care Program (ADHC) exists at nine VA medical centers. Five programs have been established following the passage of P.L. 98-160 and programs will commence operation during FY 1985. The other four programs were initiated prior to the legislation to meet local needs.

ADHC is a therapeutically oriented ambulatory day program which provides health maintenance and rehabilitative services to frail individuals in a congregate setting during daytime hours.

The purposes of ADHC within the Veterans Administration are:

1. To enable functionally impaired veterans to reside in supportive home environments rather than in nursing home care facilities.
2. To facilitate the return of older veterans to their homes, and coordinate their long term care thereby reducing readmissions, length of stay and use of hospital and nursing home beds, and to improve health care seeking behavior.
3. To maintain older veterans at the highest level of physical and social functioning possible.
4. To improve the quality of life for veterans by providing a rehabilitation program in the community among their peers.
5. To provide support for the family and other caregivers to enable them to maintain older veterans in the community.

The VA's approach to ADHC follows a health focused model of care. Palmer, 1/

1/Palmer, H,C.: Adult Day Care. In: Long Term Care, Perspectives from Research and Demonstrations. Vogel, R.J. and Palmer, H.C., eds. Aspen. 1985.

in his review of ADHC taxonomies, lists two published classification schemes. The first by Trager, 2/ in 1979 reported on three ADHC models:

1. Restorative Care - an intensive health care focus, emphasizing supervision, individual therapies, medical and psychosocial services for a period of time, usually less than four months.
2. Maintenance Care - a less intensive level of service delivery, yet emphasizing individual treatment plans, periodic reassessments, and group therapies, usually for a longer period of time.
3. Social Care - an activity oriented program offering services in a protected environment and arranging for therapies outside the program.

The second classification scheme, offered by Weissert in 1976, developed two models of ADHC based on a comparative study. He concluded:

> "Model I adult day care is a physical rehabilitation program. Participants need professionally administered rehabilitative physical, occupational, and speech, and hearing therapy. They exhibit multiple chronic conditions and functional impairment including a high incidence of being wheelchair-bound and a high incidence of paralysis and stroke. Most require assistance in walking, some require assistance in wheeling, and many require assistance in toileting or they are frequently incontinent.
>
> Model II programs are a pot pourri. Program goals suggest social rehabilitation, maintenance, alleviation of social isolation, nutrition, recreation, and health care services. But health services delivery is not particularly stressed as in Model I. 3/

Weiler, in an address at a VA sponsored conference on ADHC in 1983, provided a

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2/Trager, B.: Adult Day Health Care - A Conference Report. National Center for Health Services Research, May, 1979.

3/Weissert, W.G.: Two Models of Geriatric Day Care: Findings From a Comparative Study. The Gerontologist, October 1976.

comparative review of services offered by health focused and social focused day care.

	Adult Day Health Care	Social Day Care
Medical Evaluation	Complete medical and diagnostic evaluation provided by or coordinated by the center	Not provided or referrals made if needed
Medication	Supervised by staff Possibly administered by nurse	Self administered Patient responsible for own
Prescriptions	Complete drug history and review Prescriptions provided through center	
Treatment	Medical/Dental Rehabilitation OT, PT, ST. Nursing Counseling Psychosocial Therapeutic recreation	Physical fitness Hobbies Social activities
Personal Care	Analysis of ADL needs and remedial action	Minimal
Nutrition	Special and regular diets Supervision Nutritional counseling and education	Usually regular meals only
Transportation	Part of program	Usually arranged by participant
Social Activities	Planned objectives Resocialization Group Work	Participant initiated programs
Follow-up	Tracking	Information & Referral (I&R) 4/

By statutory and programmatic design, the VA has introduced Adult Day Health Care using a health model, classified as restorative and maintenance care by Trager and Model I by Weissert.

4/Veterans Administration, Office of Geriatrics and Extended Care, Adult Day Health Care: Proceedings of a Conference. Minneapolis, Minnesota, August 1983.

Studies of Adult Day Health Care

ADHC has not experienced the quantity of evaluative research that home care programs have because ADHC programs were developed later in time in this country than home care and the variety of funding souces have not been available. In general, the studies that have been conducted have examined the ADHC population's characteristics and utilization of services as an alternative to a nursing home care population and the studies have examined the cost effectiveness of ADHC.

Three States, Massachusetts 5/, California 6/, and New Jersey 7/, have evaluated their ADHC programs and have found them to be cost effective in serving a population that is either eligible for institutional long term care or "at risk" of institutionalization. All three studies have been criticized on the following grounds noted by Palmer:

> "Neither one specifies desired outcomes, assesses the vulnerability of the client population to institutionalization, provides much evidence of the comparability of experimental and control groups, or develops evidence that the services provided and the clients served were actually comparable between ADC and other types of care with which comparisons were made." 8/

Palmer continues:

> "Nonetheless, these descriptions offer a rich set of institutional facts and provide insights on the type of research designs which would enable us to use their data and their institutional backgrounds to best advantage. They also contain some analytical insights." 9/

(Palmer did not review the New Jersey study; however, the same criticisms apply.)

5/Klapfish, A.: Adult Day Care in Massachusetts Medical Assistance Program Year End Report for Fiscal Year 1978, in Trager, 1979.

6/California Health and Welfare Agency: Evaluation of Adult Health Care Programs in California. June, 1982.

7/Kurland, C.H.: The Medical Day Care Program in New Jersey. Home Health Care Servics Quarterly, Vol. 3(2), Summer 1982.

8/Palmer, 1985.

9/Ibid.

A major randomized control study, at six sites with over 1,000 patients, (Weissert, 1980) 10/ did not find that ADHC was cost effective and raised serious questions as to whether ADHC could substitute for institutional care or divert patients from an institutional setting. However, the study has also been criticized in its design and methodology, as reported by Palmer 11/, for its time-limited nature, data problems, failure to distinguish costs among sites, and shortcomings in the cost analysis itself.

General Summary and Conclusions of the Literature Review

Three major conclusions can be drawn from the evaluation research to date.

First, evidence of the cost effectiveness of ADHC is unclear. Except for the area of patient satisfaction (patients and families are more pleased with ADHC than with nursing home care), the results are equivocal on physical functioning, mortality and costs in comparison to nursing home care.

Second, from a programmatic perspective, the evaluations have provided important insights on successful programs. Weiler reviewed these findings on efficient programs in the 1983 VA conference:

"1. Geriatric expertise and support in the sponsoring agency.

2. Active, effective linkages with other components of the long term care system, e.g., home health care, domiciliary care, social services.

3. Strong administrative support from the sponsoring agency.

4. Sufficient patient referral sources.

5. Strong provider support.

10/Weissert, W.G., et al: Effects and Costs of Day Care Services for the Chronically Ill: A Randomized Experiment. Medical Care, Vol. 18, No. 6 June, 1980.

11/Palmer, 1985.

6. Strong community support." 12/

Weiler also noted the three clinical aspects of successful ADHCs:

"1. multidisciplinary team assessment both for determining eligibility in the program and for ongoing assessment,

2. individualized treatment and service plan with therapeutic objectives for each patient who is enrolled in the program,

3. periodic assessments of the participants in the program." 13/

Further research is necessary in the area of cost effectiveness of ADHC, notably in its role as a substitute for or diversion from nursing home care. The research must avoid, to the maximum extent possible, those design and methodological issues on the topics of patient and provider characteristics and on costs that have hampered the generalizability of previous evaluations.

Studies of the VA's Adult Day Health Care Program (ADHC)

Under the authority of Public Law 98-160, the VA has established five Adult Day Health Care Program. These programs will commence operation in the summer of 1985. The five VA medical centers were chosen through a solicitation process Fourteen VA medical centers responded to questions which assessed the need for ADHC, program design issues, the availability of strong medical leadership, the potential for recruiting staff, the strength of the medical center's discharge planning process, the proposed role of ADHC in the continuum of care, appropriate congregate space and the provision of transportation services. These questions addressed the critical elements highlighted in the Weiler presentation mentioned above.

A 1983 VA conference on ADHC brought together a three member team from twelve

12/Veterans Administration, August 1983.

13/Ibid.

VAMCs interested in ADHC with nationally recognized experts from the non-VA sector to explore the concept, planning, implementation, and evaluation of ADHC.

One aspect of the conference examined the five existing ADHC Programs in the VA. These programs were also the subject of an evaluation commissioned by the VA. These programs were initiated at the local level prior to the passage of P.L. 98-160 and did not have the opportunity to integrate the program guidance which was developed following the legislation. Of the programs in existence before the legislation, Capitman found:

> "The existing programs differ markedly as a result of this diversity, but program designs have been shaped by the limited resources available to their development as much as through articulation of a ADHC strategy best tailored to local VAMC needs. Nonetheless, all programs were developed in response to a common set of problems in the VA sustaining care delivery system, though the relative importance of these issues varied. In particular, each of the hospitals that sponsored a day care program faced issues such as the following:
>
> - excessive demand for NHCU and community nursing home services;
> - excessive demand for VA inpatient care;
> - excessive demand for ambulatory services by geriatric patients; and
> - decreasing ability to provide adequate follow-up care.
>
> ADHC programs were developed as one component of a broader strategy to increase the cost-efficiency and service-effectiveness of the VAMC's program for geriatric and other disabled patients. Resource limitations and the particular expertise of available personnel are important ingredients in program design. Each of the ADHC strategies may still be described in terms of three dimensions." 14/

Capitman summarized his findings (Table 1) on the five existing programs along

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14/Veterans Administration, Office of Geriatrics and Extended Care. Adult Day Day Health Care Programs Within the Veterans Administration Medical Center System, October 1983.

Table I

Summary of the Existing VA - ADHC Strategies

Program	Target Group	Most Feasible Utilization Control Goals	Systems Integration
North Chicago	Noninstitutional level, low personal care needs, high rehabilitation potential, strong-to-fragile informal support	Acute care control Outpatient care control	Strong case management of all services Some involvement in hospital-wide care/discharge planning Center as locus for broad array of other services
Butler	Noninstitutional level, low personal care needs, high rehabilitation potential, strong-to-fragile informal support	Acute care control Outpatient care control	Some case management of all services Strong involvement in hospital-wide care/discharge planning Center as locus for broad array of other services
Yucaipa	Institutional- and near-institutional level, moderate-to-high personal care needs, all ranges of rehabilitation potential, strong-to-fragile informal support	Prevention/diversion from institutional care Substitution for institutional care	Minimal integration Community consortium model
American Lake	Near-institutional level, low-to-moderate personal care needs, moderate-to-high rehabilitation potential, fragile informal support	Outpatient care control Acute care control Prevention/diversion from institutional care	Some case management of all services Minimal involvement in hospital-wide care/discharge planning Center as locus for a few other services
Palo Alto	Institutional and near-institutional level, moderate-to-high personal care needs, low-to-moderate rehabilitation potential, fragile informal support	Substitution for institutional care Prevention/diversion from institutional care	Minimal case management of all services Minimal involvement in hospital-wide care/discharge planning Strong involvement with other respite and proposed integration with HBHC Center as locus for a few other services

three variables: Target Group, Most Feasible Utilization Goals, Systems Integration.

VA program officials have continued to work with the pre-1983 ADHC programs to bring them into compliance with the law.

General Summary and Conclusions of Evaluative Studies on VA ADHC

Three conclusions can be drawn from the VA's development of ADHC.

First, the VA has evaluated those ADHC Programs which existed prior to the legislation and continues to work to improve their utilization and efficiency.

Second, the VA has established five ADHC Programs under P.L. 98-160 following a restorative/maintenance model. This program design is best illustrated in the guidance on patient selection:

> "C. PATIENT SELECTION
>
> In order for a veteran to be admitted to an ADHC center, the following conditions must be met:
>
> 1. Veteran must be eligible, as defined above; [eligible for and in need of Community Nursing Home Care]
> 2. Veteran would, without ADHC services, most probably be in a nursing home (see below);
> 3. Most of the veteran's health care needs can be met in the ADHC center without the need for VA outpatient services;
> 4. Veteran has a supportive living arrangement sufficient to meet his/her health care needs when not at the ADHC center;
> 5. Suitable transportation can be arranged between the veteran's home and the ADHC center;
> 6. Veteran lives no further than one hour's travel time from the ADHC center.
>
> In determining whether the patient would, without ADHC, be in a nursing home, the following tests can be used, in descending order of certitude:
>
> 1. Veteran has been referred to ADHC from a nursing home, or

2. Veteran has been referred for and in the process of going to a nursing home, or

3. A combination of factors indicate that the veteran should be in a nursing home. The most common set of factors which indicate this need are:

   a. Dependence in two or more functional Activities of Daily Living (ADL) and dependence in three or more of the Instrumental Activities of Daily Living (IADL) plus at least two of the following:

      (1) Frequent utilization of outpatient clinics (more than 12 times per year).

      (2) Advanced age (75+).

      (3) Complex medicine regimen (three or more prescription medications per day).

      (4) Clinical depression.

   b. It is emphasized that the above combination of characteristics are indicators only and do not comprise a foolproof justification of need for ADHC. Ultimately, a clinical judgement must be made, with written justification, as to veterans need for ACHC." 15/

Third, in authorizing the VA to provide adult day health services, Congress mandated a study of the medical efficacy and cost effectiveness of ADHC. The VA is committed to conducting such a study and has developed a research proposal utilizing a randomized design, with special attention to target the patient who would otherwise actually be in a nursing home. The proposal has been scrutinized by a body of national experts in health care research and evaluation and, if carried out, shows promise of providing a definitive answer, both for the VA and for the health care community at large, to the cost effectiveness and targeting questions.

15/Veterans Administration, Office of Geriatrics and Extended Care. Adult Day Health Care: Draft Program Guidance, January 1985.

GERIATRIC EVALUATION UNITS (GEUs)

Program Nature and Scope

The Geriatric Evaluation Unit (GEU) Program is currently in operation at 40 VA medical centers and provides comprehensive assessment of older patients who have multiple and potentially reversible, medical, functional, social, and psychological problems associated with aging. An interdisciplinary health care team consisting of at least a physician, nurse, and social worker performs this comprehensive assessment.

Many elderly people enjoy healthy and active lives, but the degenerative processes associated with aging leave older persons more susceptible to certain diseases and affected by some diseases with age specific complications. The degenerative changes in tissues and organ systems of the elderly also mean that they are plagued by a host of chronic illnesses occurring simultaneously. The elderly's unique and complex health care problems present a serious challenge to health care professionals. Assessment, treatment, and management of these problems requires specialized knowledge of and sensitivity to older patients' medical, functional, psychological, and socio-economic characteristics.

Only an interdisciplinary team approach to health care can adequately address the diverse problems inherent in caring for older patients. What is unique about this approach is the much higher level of interaction among the various disciplines represented on the team. Team members interact by frequently exchanging information about patients' assessment status, treatment plan, and response to treatment. They share a common goal and coordinate their activities to achieve that goal.

A Geriatric Evaluation Unit (GEU) refers to the inpatient or outpatient setting where an interdisciplinary health care team performs a multidimensional assessment of older patients' medical, functional, psychological, and socio-economic status. Traditional medical diagnosis is a necessary component of this comprehensive assessment, but it alone is not sufficient. In an inpatient setting this activity may be confined to a group of dedicated beds on an acute care or intermediate care ward of the hospital. An interdisciplinary team may also perform comprehensive assessments of geriatric patients on a consultation basis either as an extension of the activities conducted on a dedicated bed unit or independent of such a unit. A GEU in an outpatient setting can provide evaluation of patients on an ambulatory care basis or provide follow-up assessment and care for patients discharged from the hospital.

The comprehensive assessment performed on a GEU is valuable in that it may identify hidden disabling conditions and better manage previously detected problems which, if left untreated or improperly treated, would compromise patients' optimal recovery. It also helps to identify the least intensive level of care by better matching available services with patient needs.

In addition to providing improved care for older patients and improved utilization of long term care services, a GEU provides an excellent setting for geriatric training, education, and research.

Studies of Comprehensive Geriatric Assessment and Geriatric Evaluation Units

The concepts of comprehensive geriatric evaluation and specialized geriatric evaluation units were first developed in Great Britain during the 1930s and were based largely on the work of geriatrics pioneer, Marjory Warren. After assuming clinical responsibility for the chronically ill at a large London infirmary for the indigent, Dr. Warren found many neglected older patients who had not received proper assessment of or treatment for their disabling conditions. Through systematic evaluation of these patients and more appropriate treatment of their conditions, she was able to discharge a large number of patients to their homes previously thought to lack rehabilitation and discharge potential. As a result of her experiences, Dr. Warren advocated the establishment of special geriatric units in hospitals for the purpose of assessing and treating the chronically ill elderly before admitting them to long term care homes. The care of these patients, she added, should be undertaken by an interdisciplinary team that involves medical, nursing, social work, and rehabilitation therapy input. 1/

The "progressive geriatric care" which Dr. Warren helped to initiate and which now characterizes the health care systems of Britain and much of Western Europe is centered on comprehensive geriatric evaluation. In municipalities in both Denmark and the Netherlands, geriatric assessment teams have been established to rule on all applications for institutional care. These interdisciplinary teams have been effective in diverting many older people from institutional forms of care, allowing them to stay on in their own homes with appropriate community services. 2/

In the United States geriatric evaluation programs have been developed only recently. One of the earliest reports of such a program in the United States came from Dr. T. Franklin Williams' outpatient assessment program in Monroe County, New York. Findings from this study, published in the Journal of the American Medical Association in 1973, indicate that as a result of comprehensive evaluation of 315 chronically ill elderly persons recommended initially by

1/Warren, Marjory W., "Care of the Chronic Aged Sick," The Lancet, June 8, 1946, pp. 841-843.

2/Nusberg, Charlotte. Innovative Aging Programs Abroad, Westport, Connecticut, Greenwood Press, p. 72.

a professional person or family for nursing home placement, only 35% were found to need nursing home care. More than 30 percent of these patients were recommended for placement in a supervised boarding home, and almost 23 percent were enabled to continue living in their own homes with some assistance as needed from home care services. Williams, et al, estimate that the potential yearly savings in Medicaid expenditures for Monroe County alone would be at least $2 million, if all chronically ill, elderly persons being considered for long term institutional care underwent a similar comprehensive evaluation. 3/

In November 1980, Philip D. Sloane reported on the effectiveness of an inpatient GEU in a Miami general hospital in the Journal of the American Geriatrics Society. This longitudinal prospective study showed that, as a result of intensive intervention from a team of physicians, nurses, and social workers, 24 percent of the patients on a 30-bed ward assessed as needing nursing home care could be placed more appropriately in an environment where the level of care was less intensive and expensive than that of a nursing home. Those patients most likely to benefit from such a program were identified at admission by the presence of two of the following three admission characteristics: (1) a score of A or B (Katz Scale) for activities of daily living; (2) a score of 3 or less errors on the mental status scale (Pfeiffer); and (3) the presence of family members willing to care for the patient, although unable to do so at the time of admission. For each patient placed at a less intensive level of care there was an estimated yearly savings of $6,000 to $8,000 in health care costs. 4/

Findings from a controlled study of the effectiveness of an inpatient geriatric

3/Williams, T.F., Hill, J.G., Fairbank, M.E., and Knox, K.G. "Appropriate Placement of the Chronically Ill and Aged: A Successful Approach by Evaluation," Journal of the American Medical Association, 226, 1973, pp. 1332-1335.

4/Sloane, Philip D. "Nursing Home Candidates: Hospital Inpatient Trial to Identify Those Appropriately Assignable to Less Intensive Care," Journal of the American Geriatrics Society, November 1980, pp. 511-514.

unit at a Cleveland hospital, published in the Journal of the American Geriatrics Society in 1983 indicate that a significantly larger number of the patients cared for on the geriatric unit, as opposed to controls, were discharged to a home setting in the community rather than to a nursing home. Subjects on the unit also showed greater improvement in activities of daily living, ambulation, mental status, and continence than did controls. 5/

An April 1983 article in the Journal of the American Geriatrics Society describes the outcomes of 100 elderly patients considered "at risk" for institutionalization who were treated on an assessment and rehabilitation unit in a Memphis community hospital. In this article, William Applegate, et al, report that, as a result of interdisciplinary assessment and rehabilitation, 91 new diagnoses of treatable conditions were made. With these diagnostic and management changes, an average of 1.9 admission medications were discontinued and an average of 1.2 new medications were added. A large number of these patients experienced significant improvements in ambulation, activities of daily living, and motivation. At discharge only 10 percent of these patients were placed in nursing homes, and at six months only 19 percent were in nursing homes. 6/

Studies of the GEU Program in the VA

The VA medical system has taken a leadership role in the U.S. in promoting the establishment of geriatric evaluation units. There are several reasons for this. First, as a hospital based system of health care, the VA has a large number of patients at risk for long term institutional care that warrant the

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5/Lefton, E., Bonstelle, S., and Frengley, J.D., "Success With an Inpatient Geriatric Unit: A Controlled Study of Outcome and Follow-up," Journal of the American Geriatrics Society, March 1983, pp. 149-155.

6/Applegate, W.B., Akins, D., VanderZwagg, R., Thoni, K., and Baker, M.G., "A Geriatric Rehabilitation and Assessment Unit in a Community Hospital," Journal of the American Geriatrics Society," April 1983, pp. 206-210.

operation of GEUs, and this number is expected to rise dramatically during the next few decades as the World War II veterans swell the ranks of older veterans. Second, interest in geriatric educational activities in the VA has encouraged a team approach to geriatric care which is essential for the successful operation of the GEUs. Third, the current Medicare prospective payment system discourages the establishment of such units in the private sector. Fourth, the establishment of Geriatric Research, Education, and Clinical Centers (GRECCs) has stimulated the growth of these units. In fact, the VA's first experiences with GEUs occurred during the mid and late 1970s when some of the GRECCs set up GEUs as part of the clinical demonstration activities of their centers.

The first VA GEU was opened in June 1976 by the GRECC at the Little Rock VA Medical Center under the direction of Dr. Owen Beard. Among this unit's findings were 184 new major psychiatric conditions in the 241 patients transferred to the GEU from acute medical and surgical wards. 7/

At the VA Medical Center in Sepulveda, California, demonstration activities developed into a randomized, controlled study of the efficacy of GEUs. This effort, under the direction of Dr. Laurence Rubenstein, constitutes the most comprehensive scientific evaluation of GEUs to date in the United States. Findings from this study published in The New England Journal of Medicine reveal significant benefits associated with admission to the GEU. In comparison with a control group, patients in the GEU had a significantly lower mortality rate and discharge rate to nursing homes. They were also more likely to experience improvement in functional status and morale. After a one year follow-up period, the GEU patients had significantly fewer acute care hospital

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7/Chea, K. and Beard, O.W., "Psychiatric Findings in the Population of a Geriatric Evaluation Unit: Implications," Journal of the American Geriatrics Society, 1980, 28, pp. 153-156.

days, nursing home days, and hospital readmissions than the control group. 8/

During the first year of follow-up, GEU patients did spend more days in the hospital than did controls, but most of these days were spent on the GEU (an intermediate care ward of the hospital) which has a much lower per diem cost than an acute care ward where controls spent most of their hospital days. As a result, GEU patients used an average $19,406 of institutional care during the 12 month follow-up period compared to $20,329 for control patients. When the cost figures are adjusted to reflect the fact that significantly more GEU patients survived the first year of follow-up than did controls, the savings in institutional care costs per year survived were on average more than $5,000 for the GEU patient ($22,597 vs. $27,826 for control patients).

Rubenstein, et al, point out that, if the outcomes in the Sepulveda study are extrapolated to the entire U.S. population, about 200,000 nursing home admissions per year could be avoided through the nationwide use of geriatric evaluation units. Such extrapolations, they note, however, need to be made with caution until their study is replicated among a civilian population with a more typical cross section of patients by sex and socio-economic status.

The VA's public commitment to promoting the development of GEUs systemwide is illustrated by the ambitious goals set for the expansion of the program in the 1984 Agency report, Caring for the Older Veteran. It sets a goal of having operational GEUs in 70 percent of the VA hospitals by 1990 and in every hospital by the year 2000. 9/ As of January 1, 1985, the number of operational GEUs

8/Rubenstein, L.A., Josephson, K.R., Wieland, G.D., English, P.A., Sayre, J.A., and Kane, R.L., "Effectiveness of a Geriatric Evaluation Unit," The New England Journal of Medicine, December 27, 1984, pp. 1664-1670.

9/Veterans Administration, Caring for the Older Veteran, 1984.

in the VA had grown to 40. Informal reports from many of these units indicate favorable patient outcome data with respect to improvements in diagnostic accuracy, placement, and functional status.

The diversity of the GEU Programs in the VA makes it difficult to determine accurately the benefits and costs of providing this level of care systemwide. GEU programs in the VA are operated on an inpatient and outpatient basis. Inpatient programs may be located on an acute care or intermediate care ward of the hospital, or function independent of a specific bed section as a consultation team for the entire medical center. As a result, extrapolations of the cost benefits indicated in the Sepulveda study are applicable only to those similarly organized and operated programs in the VA. For example, results from a controlled study of the GEU at the Houston VA Medical Center, published in the September 1983 issue of the Journal of the American Geriatrics Society, show no significant difference between GEU and control patients in their post-hospitalization discharge status. In the Houston study, Teasdale, et al, attribute their unit's unsuccessful placement outcomes to the lack of pre-admission selection criteria which most VA GEU Programs, including the Sepulveda program, have. 10/

Efforts, however, are underway which should provide better answers to the question of cost effectiveness. A management information system is currently being developed for GEU Programs throughout the VA system. Data obtained from this system after it becomes operational will allow a more definitive analysis of GEU effectiveness. Also, the Director of Resource Management is presently responding to a request from the Assistant Chief Medical Director for Geriatrics

10/Teasdale, T.A., Shuman, L., Snow, E., and Luchi, R.J., "A Comparison of Placement Outcomes of Geriatric Cohorts Receiving Care in a Geriatric Assessment Unit and on General Medicine Floors," Journal of the American Geriatrics Society, September 1983, pp. 529-534.

and Extended Care to help determine the cost of operating a GEU. This would involve calculating the cost of an interdisciplinary health care team conducting multidimensional assessments, as well as calculating the cost of operating a group of beds for this purpose on acute care or intermediate care wards of the hospital.

General Summary and Conclusions of Evaluative Studies on VA GEUs

The consensus of the reports on GEUs is that these units can provide substantial health benefits over and above the benefits of traditional hospital approaches at a minimal cost for many chronically ill, elderly patients. The Sepulveda study indicates that a GEU can be viewed as an investment strategy. The expenditure of additional resources during a patient's stay on the GEU are recouped over the ensuing year as the GEU patient requires fewer health care resources than he or she would otherwise require.

The effectiveness of comprehensive geriatric evaluation and GEUs is best illustrated not by the quantity of resources it saves but by the quality of life it improves. Even if these units do not achieve dramatic reductions in utilization of other acute and chronic services, their value in improving quality of life and facilitating better long-term care decisions needs careful attention. 11/

11/Rubenstein, L.Z., Rhee, L., and Kane, R.L. "The Role of Geriatric Assessment Units in Caring for the Elderly: An Analytical Review," *Journal of Gerontology*, Vol. 37, No. 5, 1982, p. 521.

GERIATRIC RESEARCH, EDUCATION, AND CLINICAL CENTERS (GRECCs)

Program Nature and Scope

Geriatric Research, Education, and Clinical Centers were first implemented in 1975 and are presently funded at ten locations. In Fiscal Year 1984 the GRECCs received $4.8 million in support of 138.5 core FTEE; this was supplemented by $3.2 million in VA and non-VA research funding, which supported an additional 155.8 FTEE. During this period the programs received $11.6 million in research funding (60% of which came from non-VA sources), produced 553 publications, provided educational programming for nearly 2,400 VA health care professionals and 568 health professional trainees, and provided clinical care to more than 13,000 aged veterans.

The GRECCs were designed to concentrate and integrate, within individual "centers of excellence," the activities of innovative investigators, educators, and clinicians from diverse health science disciplines. One of the program's original purposes was to attract scientists and health science students to the field of geriatrics. In 1973, when the concept of GRECCs was first approved, the field of geriatrics was struggling to attain legitimacy and to attract interest. At that time there was no National Institute on Aging nor Administration on Aging within the Department of Health and Human Services, and there were no specific programs for training physicians, nurses, and other health care professionals in geriatrics and gerontology. GRECCs, then, were a tangible response to an early recognition of the "geriatric imperative" 1/ and the accompanying lack of resources and systems for handling the approaching surge in demand for geriatric services.

1/Somers, A.R. and Fabian, D.R. The Geriatric Imperative: An Introduction to Gerontology and Clinical Geriatrics. New York:Appelton-Century-Crofts, 1981.

Included here are descriptions of (1) the development of GRECCs as a specific VA response to the geriatric imperative; (2) the relationship of GRECCs to similar, non-VA programs; and (3) the results of two comprehensive GRECC Program evaluations.

By 1980 GRECCs had been established in eight locations and had demonstrated sufficient success that Congress, in Public Law 96-330, 2/ authorized enhancement of the existing centers and expansion of the program to fifteen locations.

GRECCs are currently located at the following VA medical centers with the indicated affiliations:

- Boston Area
  - Bedford Division (Boston University)
  - Brockton/West Roxbury Division (Harvard University)
- Durham (Duke University)
- Gainesville (University of Florida)
- Little Rock (University of Arkansas)
- Minneapolis (University of Minnesota)
- Palo Alto (Stanford University)
- St. Louis (St. Louis University/Washington University)
- Seattle Area
  - Seattle Division (University of Washington)
  - American Lake (Takoma) Division
- Sepulveda (University of California, Los Angeles)
- West Los Angeles, California (University of California, Los Angeles)

Public Law 96-330 also established criteria for the location of GRECCs and codified the program mission. GRECCs were specifically mandated to advance:

1. scientific knowledge regarding the medical, psychological, and social needs of the increasing number of older veterans, and,

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2/Public Law 96-330, Veterans Administration Health Care Amendments of 1980, Aug. 26, 1980, pp. 1048-1051.

2. the methods for meeting these needs. These advances were to be accomplished through "... geriatric and gerontological research, the training of health personnel in the provision of health care to older individuals, and the development of improved models of clinical services for eligible older veterans."

Medical centers that could host GRECCs were specified as having to meet the following criteria. They must have:

- an arrangement with an accredited medical school which provides education and training in geriatrics; and with which the medical center is affiliated;
- the ability...to provide rotations for medical residents, and nursing or other health science students through nursing home, extended care, or domiciliary units of the medical center;
- the ability to attract the participation of scientists who are capable of ingenuity and creativity in health care research;
- a location that provides an appropriate geographic distribution of centers nationwide;
- the ability to effectively conduct evaluations of the GRECCs' activities; and
- a policy making advisory committee to advise the director of the medical center and the GRECC on policy matters pertaining to GRECC activities.

The GRECC Program was, therefore, neither conceived nor implemented as an alternative to institutional care. Instead, the program was designed to create independent research and education programs that would, among other activities, develop and evaluate non-institutional alternatives for providing care to the elderly.

Studies of Other Related Programs

Currently, the agencies of the Department of Health And Humans Services (DHHS) support programs that are related in purpose to the VA's Geriatric Research, Education, and Clinical Centers Program. These programs include: (1) the Teaching Nursing Home Program sponsored by the National Institute on Aging (NIA); (2) the Geriatric Education Centers (GEC) sponsored by the Health Resources and Services Administration; and (3) the Long Term Care Gerontology Centers sponsored by the Administration on Aging (AoA). These programs are, in varying ways, similar to but distinctly different from the GRECC Program.

The Teaching Nursing Home Program was initiated by NIA in 1982. The program, which currently is funded at seven locations, is designed to "encourage research on health problems which are particularly prominent in nursing homes and among geriatric outpatients." 3/ Programs are currently located at:

- Albert Einstein Medical College (New York)
- University of California (San Diego)
- Case Western Reserve University (Cleveland)
- Harvard University/Beth Israel Hospital (Boston)
- Johns Hopkins University (Baltimore)
- University of Pennsylvania (Philadelphia)
- Stanford University (Palo Alto)

Two of these programs, at Stanford and Harvard/Beth Israel, are directly affiliated with VA GRECC programs.

The Geriatric Education Centers were initiated in 1983 for the purpose of developing regional resource centers that focus on strengthening multidisciplinary training of health professionals in geriatric health care. At present there are four GECs located at:

- Harvard Medical School (Boston)
- University of Michigan (Ann Arbor)

3/U.S. Department of Health and Human Services, National Institute on Aging, NIH Publication No. 83-1129, July 1983, p. 34.

- State University of New York (Buffalo)
- University of Southern California (Los Angeles)

These centers act as "prototypical national resources providing multidisciplinary training for health professionals in geriatric care." 4/ They facilitate training of medical, osteopathic, dental, optometric, pharmacy, podiatric, nursing, and other allied and public health students and practitioners in the prevention, diagnosis, and treatment of diseases and other health problems of the aged. The GEC located at the Harvard Medical School is closely affiliated with the Boston Area GRECC Division located at the Brockton/West Roxbury VA Medical Center.

The Long Term Care Gerontology Centers were initiated in 1980 and currently are located at the following eleven sites:

- University of Arizona (Tucson)
- Brown University (Providence)
- University of California/University of Southern California (Los Angeles)
- Columbia University (New York)
- University of Kansas (Kansas City)
- University of South Florida (Tampa)
- Temple University (Philadelphia)
- University of Texas (Dallas)
- University of Utah (Salt Lake City)
- University of Washington (Seattle)
- Medical College of Wisconsin (Milwaukee)

These centers were established to "initiate fundamental changes in the existing expensive, uncoordinated and fragmented system of long-term care." The long-term care gerontology centers are unique in that they attempt to resolve problems of

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4/Department of Health and Human Services, Report on Education and Training in Geriatrics and Gerontology. Administrative Document, February 1984.

long-term care by marshalling the combined resources and viewpoints of academicians, policy makers, researchers, planners, and community-based providers. It is a nationwide program with a multidisciplinary and multiorganizational approach that encourages joint problem-solving in the area of long-term care. 5/

GRECCs share several common elements with these programs, including, in some cases, personnel. All four programs represent attempts to advance the field of geriatrics through the application of science and academic rigor. Together, these four programs form a "critical mass" for the national research and educational efforts in geriatrics and gerontology.

At the same time, the GRECC program is are distinctly unique:

- It is the only such program entirely contained within a single comprehensive and vertically integrated health care system;
- It has major responsibilities in research, education and improved models of care;
- Investigators and students have exposure and access to populations not readily found elsewhere; and
- The opportunities for health services research are uniquely comprehensive.

Studies of VA GRECCs

Because of the uniqueness of the program and the specific mandates of the enacting legislation, the GRECC Program has undergone several comprehensive summative evaluations during its ten year history. The first of these, completed in 1980 by the Department of Medicine and Surgery, 6/ was conducted by a multidiscipli-

5/Association of Long-Term Care Gerontology Centers, Inc. Long-Term Care Gerontology Centers: A National Resource in Long-Term Care, p. 1.

6/Department of Medicine & Surgery, Geriatric Research, Education and Clinical Centers: Final Program Evaluation Report, April, 1980.

nary team consisting of VA Central Office and medical center personnel. Their final report contained the following conclusions and recommendations:

- ...the GRECCs are making impressive strides in the field of geriatrics and are altering negative perceptions regarding geriatrics in their institutions and communities. A complementary group of senior and young professionals have organized an impressive effort with minimal resources. The consensus of the site visit team was that these centers are at a critical point in their development and that additional resources must be made available or the impetus of the initial accomplishments would stagnate. Hesitation at this point will not only result in a loss for the veteran in the 1980s, but for the field of geriatrics nationally for years to come.

- That the existing GRECCs be provided with the additional resources required for their complete activation to make it possible for them to capitalize on their initial success.

- That a small number of additional GRECC demonstration programs be established, contingent upon the existing GRECCs being provided the resources necessary for their full activation.

- That VA Central Office develop a mechanism for ongoing evaluation of the national GRECC program.

- That greater emphasis be placed on geriatric health services research and development programs including those designed to evaluate the cost effectiveness of existing and planned long-term care programs of the VA.

These comments and recommendations were later expressed in concrete terms in Public Law 96-330. This law led to several subsequent program modifications: (1) the enhancement of all existing GRECCs with staff specifically designated to conduct education and evaluation activities; (2) other enhancements to GRECC core staffing based on a staffing pattern analysis conducted by VA Central Office; and (3) further efforts to promote the development of health services research within the GRECCs.

Public Law 96-330 also established a Geriatrics and Gerontology Advisory Committee (GGAC) that was directed to assess, through an evaluation process, the ability of each GRECC "to achieve its established purposes and the purposes of Title III of the Veterans Administration Health Care Amendments of 1980." 7/ Hence, a second summative evaluation of the GRECC Program was submitted to the Chief Medical Director on January 7, 1983. 8/ This report offered the following recommendations:

- o DM&S should reexamine the expectations and limitations affecting the GRECCS and host facilities as set forth in P.L. 96-330. If GRECCs are aggressively and equally to undertake research, education, and clinical care, greater resources will be necessary.
- o More effective evaluation of the GRECC activities should be instituted both in the GRECCs themselves and in Central Office.
- o Research funding for the VA should not be diminished. Research in the GRECCs can only prosper to the extent that research funds are adequate for the VA's research program in general. Appropriate administrative funds should accompany incremental research funding to the GRECCs.
- o Health Services research should be initiated to include the study of innovative models of care, including an evaluation of their cost-effectiveness.
- o It is recommended that the VA develop a standard accounting procedure and report for designated GRECC funds.

These recommendations, which in some cases reiterated the recommendations of the earlier DM&S report, led to further program modifications and the redoubling of on-going efforts related to program evaluation and health services research.

7/Ibid.

8/Health Care of the Aging Veteran: A Report of the Geriatrics and Gerontology Advisory Committee. April 1983, p. 50.

Subsequent to the release of the GGAC report, a standard accounting procedure (i.e., cost center) was established for the GRECC Program and additional efforts have been undertaken at the Central Office level to supplement existing program resources. At the same time, the GRECCs have become increasingly entrepreneurial and successful in generating resources from non-VA sources.

During the past four fiscal years (FY 81-84), written annual program summaries have provided productivity data on the total GRECC Program. These summaries have documented several dramatic increases in GRECC Program productivity. For example:

- During FY 1984 total research funding awarded to GRECC core and affiliated staff increased to $11.6 million—a 53% increase over the previous fiscal year and a 98% increase over FY 1982. Almost 60% of the present funding for GRECC aging research comes from non-VA sources.
- Total GRECC research publications increased by 28% in FY 1984, and the total number of health services research publications increased by 85%.

At the present time a "Comprehensive GRECC Program Evaluation Plan" is being finalized for implementation by GRECC program staff. This plan uses a multidimensional evaluation strategy that consists of several formative and summative components. Health services research that evaluates the efficacy and costs of alternatives to institutional care for elderly veterans will be central to this comprehensive evaluation plan.

A third summative evaluation is currently being completed by the Office of Program Planning and Evaluation within the VA Administrator's Office. This report is expected to be released within the next several months.

General Summary and Conclusions of Evaluative Studies on VA GRECCs

From the summative evaluations conducted thus far, it seems fair to conclude that the GRECCs have, with limited resources, demonstrated their value and contribution to the overall VA response to the geriatric imperative. GRECCS, in collaboration with other VA and non-VA programs, have made a significant contribution to the advancement of geriatrics as a clinical specialty and as a field for ground breaking research. Nevertheless, much work remains to be accomplished. Current resources to provide education and training in geriatrics continues to be very limited. This situation reflects the modest resources which have been devoted to training and research focused directly on aging and the aged. It is estimated that only about one percent of expenditures for training and research in the health field is concerned specifically with these issues. 9/ New knowledge and fundamental understanding gained through research is the ultimate service and the ultimate means of cost containment. Without new knowledge through research, we will continue in our old ways at ever increasing costs. 10/

The large expenditures for health care of the elderly could be spent more efficiently and effectively if more health care professionals had education and training in geriatrics and gerontology. The added knowledge and skills resulting from such preparation would make health personnel more proficient in dealing with the special conditions of the elderly, more skilled in utilizing scientific advances, and more sensitive to personal needs. 11/

9/Report on Education and Training in Geriatrics & Gerontology, op cit., p. 13.

10/Changes...Research on Aging and the Aged. U.S. Department of Health and Human Services, NIH Publication No. 81-85, October 1980, p. 32.

11/ Somers and Fabian, op. cit., 1981.

Question: 7.A. What do you project will be the geographic, age, and income distributions of the so-called "low priority veterans" who will not be treated in FY 87 if the proposal set forth on page 5-16 of the VA's budget documents is implemented?

Answer: Although the specific information you have requested is not available, a general reply is possible. There are, of course, no low priority veterans, but there are veterans whose status as claimants to veterans benefits is less compelling than other veterans. Various analyses have shown that generally non-service connected veteran users of the VA health care system have incomes that are lower than both veterans in general and the public in general. Insofar as age is concerned, as age is currently irrelevant in terms of treatment priorities, there is no reason to believe that the age distribution of the lower priority groups is any different than the age distribution of the higher groups. Geographically, the North East and Mid-West have somewhat higher concentrations of non-service connected veterans in their patient mix than do other parts of the country.

Question: 7.B. Since the term "low priority veteran" is not used in existing law or in the health care eligibility legislation proposed by the Administration last year, how do you define that term?

Answer: The term "low priority veteran" is used in generic sense to refer to those veterans whose legal status is such that they fall into treatment categories at the lowest end of the treatment priorities. Both Title 38 U.S.C. and VA regulations establish these priorities, and the term "low priority" refers to eligible non-service connected veterans who are not in receipt of aid and attendance benefits, who are not former POWs or veterans of WWI or the Mexican Border Period, and who do not require care for conditions possibly related to exposure to Agent Orange or to ionizing radiation. Within this "low priority" group, higher priority is given to veterans in need of post-hospital care and pre-bed care then to those who need care to obviate hospitalization.

Question: 8. Please describe the nature and purpose of the "Most efficient organization" studies mentioned on page 5-21 of the VA's budget documents and any relationship they have to the OMB Circular A-76 requirements for the VA to study various jobs performed by VA employees for possible contracting out to private sector entities?

Answer: The "Most efficient organization" studies referenced on page 5-21 are studies which will review activities not scheduled to undergo A-76 cost comparison studies. These studies are internal management reviews that are conducted to improve efficiency and increase the productivity of an organization. While the study approach and techniques utilized are similar to an A-76 cost comparison study, an internal most efficient organization (MEO) study does not result in a cost comparison with private industry or contracting out if private industry is cheaper. The intent is solely to improve and enhance our in-house operation. DM&S has identified five activities for internal MEO studies: Dietetic Food Service, Housekeeping Services, Plant Maintenance, Medical Information, and Office Operations. These studies are scheduled to be conducted at our medical centers during FY 86 and FY 87. The studies will be evaluated by medical center management and any improvements implemented; but in no instance will an activity or any employee's position be contracted out as a result of conducting the studies.

Question: 9. In connection with our Committee's February 20, 1985, hearing on the VA's budget, I asked a question about the relationship between the cost to the Federal Government of an episode of care for an individual in the VA as compared to the same care in a non-VA facility reimbursed through Medicare. The VA's response indicated that

> Data are currently being gathered from a variety of states and payers in order to make such a comparison. These sources will include, if available, data on Medicare reimbursement. These studies should be available by September 1985.

What is the current status of those studies?

Answer: The cost comparison analysis comparing the cost of an episode of acute care in the VA with the cost in non-VA facilities has been completed and is awaiting review by non-VA consultants. Comparisons have been made with data from Medicare, the Medicaid program in the State of Utah, all-payer data from Maryland and California, and cost data from a large teaching hospital in the Northeast.

Findings show that VA costs are significantly less than most hospitals are charging similar patients, although VA costs per case are higher than Medicare and Medicaid will reimburse. Moreover, where actual non-VA cost data were available, the VA cost per case is less. The data and the analyses support the conclusion that VA acute-care costs are consistent with, and comparable to, costs in the private sector.

Question: 10. A. (i) What are the funding and FTEE levels proposed for the readjustment counseling program for each of FYs 1987, 1988, and 1989?

Answer:

	FY 1987	FY 1988	FY 1989
Funding	$40,542,000	$40,542,000	$40,542,000
FTEE	794	794	794

NOTE: Funding levels for the outyears are estimates only and are subject to revision in response to any decrease in need for and utilization of services on the part of Vietnam era veterans which may occur. The agency's intention is to decrease the size of the program in response to decreases in need.

Question: (ii)(a) What are the funding and FTEE levels for this program in FY 1986? (b) What effect will the March 1 sequestration have on these levels?

Answer:

(a) Total Funding	$40,542,000
Vet Centers	$34,292,000
Contracts	$ 6,250,000
FTEE	794

(b) Not yet determined.

Question: (iii) What were the final expenditures and FTEE levels for this program in FY 1985? (Please provide a breakdown of expenditures for the direct service and fee-for-service portions of the program.)

Answer:

Total Expenditures	$38,687,321
Direct Service	$31,435,998
Fee/Contract	$ 7,251,323
FTEE	725

Question: B. (i) How many total Vet Centers and how many Satellite Centers will be operational in FY 1987?

Answer:

Vet Centers	161
Satellites	28

Question: (ii) Will all currently planned Vet Centers or Satellite Centers be operational during FY 1986?

Answer: Yes.

Question: C. How much will be expended for fee-for-service readjustment counseling in each of fiscal years 1986 and 1987?

Answer:

FY 1986	$6,250,000
FY 1987	$6,250,000

Question: D. How many FTEE are being and will be used in fiscal years 1986 and 1987 to monitor the fee counseling contracts?

Answer: There are 18 FTEE designated as full-time in the contracts monitoring function. In addition, other program regional staff, including Regional Managers, Deputy Regional Managers, and Associat Regional Managers, devote time to monitoring the contracts program. The same is the case for Medical Administration, Fiscal, and Supply Service staffs at most medical facilities, which provide support fo administration of the program.

Question: E. How many FTEE will be assigned to the Central Office Readjustment Counseling Service out of the MAMOE appropriation and how many FTEE will be assigned to regional readjustment counseling functions in fiscal years 1986 and 1987?

Answer:

	MAMOE FTEE	REGIONAL FTEE
FY 1986	10	55
FY 1987	10	55

Question: F.(i) How much will be expended by the Readjustment Counseling Program or otherwise to carry out the Vietnam Veteran Resource Centers Pilot Program mandated by section 105 of P.L. 99-166?

Answer: Not yet determined.

Question: (ii) Please describe the efforts that will be undertaken in the VVRC program in each of the following areas and the personnel and funding resources associated with each:

(a) counseling with respect to, and assistance in applying for, VA benefits;

(b) employment counseling, training, placement, and related services;

(c) intake referral, and follow-up services with respect to disabilities related to alcohol or drug dependence or abuse; and

(d) assistance in coordinating benefits and services.

Answer: P.L. 99-166 provided the VA with the authority to proceed with the VVRC program. At this time we are developing plans to implement that program. However, because of budget restraints and other priorities we are not able to say at this time how many VVRCs we will be able to open.

Question: 11. Your budget documents show (pages 5-16 and 5-44) that beneficiary travel expenditures will, as a result of your administratively-established program reform limiting reimbursements to the cost of emergency special mode transportation, decrease from $103.5 million in FY 86 to $10 million in FY 87.

A.(i) Please provide the amounts expended for the cost of such emergency special mode transportation in each of FYs 84 and 85 and the estimated amount of such expenditures for FY 86.

Answer: We do not collect data which reflect the actual amounts expended.

The following estimates are:

FY 84	$12,711,828	(Service-connected $4,830,495 and nonservice-connected $7,881,333)
FY 85	$13,661,476	(Service-connected $5,191,361 and nonservice-connected $8,470,115)
FY 86	$14,000,000 - $17,000,000	(Service connected $6,379,820 and nonservice-connected $10,409,180)

Question: 11.A.(ii) What amount did the VA request that OMB allow to be included in the FY 87 budget for such transportation?

Answer: Originally $105,200,000 was requested for beneficiary travel. In the course of budget discussions, given the need to reduce the deficit, we agreed that it was most appropriate to target benefits on emergency travel, for which we then estimated to be $10 million.

Question: 11.B. Please provide the amounts expended for the cost of beneficiary travel reimbursements (not including emergency special mode transportation) paid, in each of FYs 84 and 85 and estimated to be paid in FY 86, to persons whose travel was for the purpose of receiving health care for or in connection with a service-connected disability.

Answer: We do not collect data which reflect the actual amounts expended.

The estimates are:

FY 84	$40,157,000
FY 85	$43,157,000
FY 86	$44,223,000

Question: 11.C.(i) To what extent are VA medical centers using helicopter services on a non-emergency basis in order to provide VA hospital care in cases in which ground transportation would be infeasible and the VA's alternative is to contract for care that would be more costly to the VA?

Answer: We do not know.

Question: 11.C.(ii) Will your new policy eliminate VA payment for such non-emergency air transportation?

Answer: Yes.

Question: 12.A. What do you estimate would be the FY 86 administrative costs of implementing the provisions of sections 19011-13 of the proposed "Consolidated Omnibus Budget Reconciliation Act of 1985", as agreed to in conference (H. Rept. No. 99-453), relating to revisions in VA health-care eligibility and to the recovery of the costs of certain health care from insurance carriers? (Assume a July 1 date of enactment and effective dates of October 1 for sections 19011 and 19012 and July 1 for section 19013.

Answer: If the third party recovery program were to be initiated on July 1, 1986, 160 full time employees would be required. As these employees would be on the rolls for a three month period, they would equate to 40 FTE with a salary cost of approximately one-half million dollars.

Administrative costs for FY 86 would be approximately one to two FTE per medical center, meaning 298 FTE would be assigned to begin working on the program in the month of September.

Question: 12.B. Please compare those estimated costs with the estimated costs of implementing your proposed means test for health-care eligibility and your proposal for recoveries from insurance carriers and explain any differences.

Answer: Our original estimate for third-party recoveries covered administrative costs for a full fiscal year and were for 160.5 FTEE and $2.27 million. This estimate was based on a workload of 250,000 bills focusing on recovery for inpatient care (greater return/bill).

Our proposed means test had associated administrative costs of $5,282,000 and 298 FTEE.

Question: 12.C. An OMB document entitled "Management of the United States Government", which was submitted with the President's budget, contains a table (on page 113) that indicates that use of a means test for VA medical care would produce budget savings of $386 million in FY 1987 and a total of more than $4.1 billion over the 5 years FYs 1987-91. Also, on page 5-16 of the VA budget documents, it is implied that the Administration's means test would produce savings of $351 million in FY 1987. However, last year the Administration claimed no cost-savings for its proposed means test, and no savings are claimed for the proposal in the listing of proposed legislation with a budgetary impact, set forth on page 24-14 of the VA's FY 1987 budget documents. Please state what the Administration's position is regarding the budgetary impact of its proposed VA health-care means test and explain the apparent discrepancy between the VA and OMB documents.

Answer: The inference that the means test will itself result in savings of $351 million is misleading. The Agency position has been that the means test involves the issue of fairness and equitable access to VA medical facilities. It is believed that the means test may produce little if any savings and there are implementation costs. As discussed in the answer to question seven, the savings will come from treating fewer veterans in the lowest priority categories. The estimate on page 24-14 of the VA's 1987 budget includes $1,560,000 for the administration of a "means test" and does not reflect any savings. The designation of the $386 million in savings reflected in the OMB management document is unknown.

Question: 12.D.(1) What FTEE Levels (and associated funding) are included in the proposed budget for FY87 for the implementation of the means test and third-party reimbursement proposals?

Answer: There are 99 FTEE included in the FY87 budget for implementation of the means test with associated funding of $1,560,000. No FTEE and no funding are included for third-party reimbursement.

Question: 12.D.(ii) To which VA departments or offices will these FTEE be assigned?

Answer: To VA medical centers and outpatient clinics.

Question: 12.D.(iii) How were these personnel levels determined and on what assumptions were they based?

Answer: These levels were determined through discussion and compromise with OMB. Much of the information that will be needed from applicants to implement both a means test and third party reimbursements is already collected.

Question: 12.D.(iv) Did the Agency seek from OMB personnel in addition to those levels for these new initiatives?

Answer: The original request included 298 FTEE and $5,282,000 for Administration of the means test and 161 FTEE and $3,184,000 for third-party reimbursement.

(It should be noted that the above answers are directed to implementation of the means test and third party reimbursement by the Department of Medicine and Surgery and does not include any reference to the 25FTE and $952,000 that is requested for the Office of General Counsel.)

BENEFITS

QUESTION 1: Last year, in connection with the Committee's February 20 hearing on the VA's FY 1986 budget, the VA indicated that it was "too early to tell what specific savings will be realized" from the provisions of section 2511 and 2512 of the Deficit Reduction Act of 1984, relating to property acquisition and cash sales. Please provide an analysis of the impact of those changes on the Loan Guaranty Revolving Fund in FY 1986 and those projected for FY 1987.

Response: The collection of a one percent funding fee has generated additional revenue to the Loan Guaranty Revolving Fund. The FY 1987 Congressional budget indicates that VA expects to collect $121.4 million during FY 1986 and $145.4 million in FY 1987 from funding fee income. Therefore, the provision of the Deficit Reduction Act that increased the funding fee and deposited this revenue into the Loan Guaranty Revolving Fund has contributed significantly towards the solvency of the Fund.

The mandate for cash sales at a minimum of 25 percent has required VA to take certain steps to facilitate the sale of VA-owned properties. Specifically, VA has offered 10 percent discounts for cash, sales commission bonuses over and above the normal 5 percent, held public auctions, paid reasonable discount points, and accepted purchase offers below our stated list prices. As a result, the inventory on hand a year ago (22,041) has declined to 19,503 as of December 31, 1985. The high level of property sales has also generated additional revenue to the Revolving Fund.

QUESTION:

2A. For each of the next 5 fiscal years, please provide an analysis of the amount of VA home loan guaranty fees that would be collected if the fee were to remain at its present 1-percent level and the amount that would be collected if the fee were to be increased pursuant to your proposal for raising it incrementally to 3.8 percent by fiscal year 1990.

2B. Please also provide for each of those years an estimate of the number and total dollar volume of VA-guaranteed loans that would be granted if the fee were to remain at 1 percent and if it were to be increased as you propose.

2C. Taking into account the availability of transfers from the Direct Loan Revolving Fund, please indicate the amounts of appropriations that you estimate will be required to be made to the Loan Guaranty Revolving Fund in each of FYs 1988 through 1990 (i) if the fee remains at 1 percent and alternatively (ii) if it is increased each of those years as you propose.

RESPONSE:

2.A. The following chart describes the amount of revenue VA expects to collect under the current fee structure (one percent) and the proposed incremental fee (the new fee amount is shown in paranthesis). The third column reflects the impact of the legislation on the level of fees collected. It should be noted that in 1988 - 1991 there has been a slight adjustment in the level of fees collected. This reflects a technical readjustment and not a change in estimates or policy:

(dollars in thousands)

Fiscal Year	One Percent Fee	Proposed Fee	Difference
1987	$145,372	$277,172 (2.0%)	$131,800
1988	142,358	333,938 (2.5%)	191,580
1989	141,330	386,230 (3.0%)	244,900
1990	139,892	448,292 (3.8%)	308,400
1991	139,158	443,958 (3.8%)	304,800

2.B. The table below contains the number and dollar amount of loans the VA projects it would guarantee with the current funding fee of one percent and the proposed fee structure (dollars are in thousands). It should be noted that these workload levels reflect the estimates used the President's Budget. Since the time the budget was submitted the VA's home loan interest rate has dropped (to a current level of 9.5%) and Congress has raised the 1986 base to $18.2 billion. However, this chart does reflect the relative impact an increase in the rate would have on the loan demand:

Fiscal Year	One Percent Fee		Incremental Fee	
	Number	Amount	Number	Amount
1987	200,000	$13,948,008	190,000	$13,250,600
1988	189,000	13,857,293	175,000	12,830,825
1989	179,000	13,802,795	161,000	12,414,871
1990	169,000	13,708,070	140,000	11,355,820
1991	160,000	13,657,808	132,000	11,267,652

2C. VA does not project a need for appropriations in FY's 1988 through 1990, either with the current one percent fee or with the proposed incremental fee. The additional fee is necessary to provide a reserve for future loss and to ensure that the program continues without additional appropriations.

QUESTION:

3. In connection with your proposal to limit the payment of the burial plot allowance to those instances where a veteran is eligible for a burial allowance, please indicate the change in workload that would result from such a change (including any change in FTEE).

RESPONSE:

3. While there will be a significant FY 87 cost savings in benefit payments associated with this proposal, we don't anticipate a significant drop in the number of claims filed during the first year (FY 87). It will take some time for information concerning the enactment and provisions of the new law to be disseminated. Also, many claims for the plot allowance come from funeral directors and cemetery owners who have no knowledge as to the veteran's entitlement to VA compensation or pension. They will file claims based on the possibility that there will be entitlement. In addition, our experience during FY 82 (the year following the change in the eligibility requirements for the basic burial allowance) was that the volume of claims received increased because the publicity concerning the law change brought in claims from people who were not previously aware that the VA had a burial benefit program. For these reasons we are not projecting an FTEE decrease for FY 87 based on this proposal.

CONSTRUCTION

Question: 1. With respect to your FY 1987 medical construction proposal, please provide a listing of the 20 projects identified for funding in FY 1987 in the VA's December 1985 Five Year Medical Facility Construction Needs Assessment according to the prioritization methodology developed last year by the VA and, to the extent that the VA's construction request for FY 1987 does not reflect this prioritization, provide an explanation and justification for the changes.

Answer:

VAMC	Project	Final Score	FY 1987 Budget Submission
Tampa, Fl	120-Bed NHCU	19	
Palm Beach, FL	New VAMC, Pt., NHC Bldgs. (Des)	18.5	
Hampton, VA	112-Bed NHCU Addn.	16.97	
Milwaukee, WI	Fire/Safety Improvements	16.87	X
Mt. Home, TN	120-Bed NHCU	16.76	
Marion, IN	240-Bed NHCU	16.34	
Salt Lake City, UT	Electrical Distribution	15.94	X
Waco, TX[1]	Renovate Bldgs. 10, 90	15.43	X
Salisbury, NC	180-Bed Geropsychiatric	15.12	X
Salem, VA	OP, Clinical, Nursing Unit Addn.	14.54	X
Knoxville, IA	Laundry Replacement	14.18	
N. Chicago, IL	Environmental Improvements (Des)	13.28	X
Baltimore, MD	Repl. VAMC	13.26	X
Huntington, WV	Clinical Improvement Addn.	13.14	
Augusta, GA	Repl. VAMC	13.02	X
Salt Lake City, UT	30-Bed SCI Center, Canteen	12.71	
Dayton, OH	Bed Addn./Renov. (Des)	12.52	X
Pittsburgh (ASP), PA	Repl. VAMC	12.36	
New York, New York	OP, Clinical Addn., Alterations	11.79	
Atlanta, GA	Clinical Addn., Parking Garage, and Seismic Stgn. (Des)	11.67	
White River Jct., VT	Research/Education Bldg.	8.43	X

[1] Project is not included in Needs Assessment.

Our FY 1987 construction budget request was arrived at using the prioritization methodology in conjunction with policy decisions made as part of the budget process. These policy issues are as follows:

Laundry: The A-76 study at Knoxville VAMC which has not been completed, will determine whether the replacement and VA operation of a laundry is more cost effective than private services. If VA-owned laundry services are proven to be the more cost effective alternative, consideration will be given for inclusion in future budgets.

Nursing Home Care: The 1987 Budget proposes a restructured long-term care policy which will place a greater reliance on the community and state programs, conversion of unneeded hospital beds at VA medical centers and non-institutional care alternatives to meet requirements for nursing home care. New construction of VA beds will be proposed if it can be clearly demonstrated that nursing home care needs cannot be met through alternative means. The NHC units which had been planned for construction in FY 1987 will be reevaluated if, in the future, the restructured policy is demonstrated to be inadequate for the needs of specific geographical regions.

Palm Beach: Palm Beach appears ninth on the list of ten medical centers currently judged most in need of construction, replacement or major modernization in the FY 1986-FY 1990 Needs Assessment. Most of the projects appearing above Palm Beach have either been funded or funds are requested for them in FY 1987. Because each of the projects on the list of ten are expensive (most over $100 million) all cannot be funded in FY 1987 given the pressing deficit reduction needs.

Waco: This project is a high priority from a fire safety and patient environment standpoint. It was identified subsequent to the preparation of the Needs Assessment as an outgrowth of developmental efforts associated with a previously funded project at Waco.

Question: 2. Please provide an explanation of the sizing methods applied to the four major replacement/modernization projects (Augusta, Baltimore, Dayton, and North Chicago) proposed in your FY 1987 budget request.

Answer: The sizes of the four major replacement/modernization projects were based on the results of the VA hospital sizing model, which was jointly developed by VA and GAO at the direction of Congress. This model projects acute hospital beds on the basis of community length of stay standards, historical utilization experience at the VA medical center, standard occupancy rates, and a survey which indicates appropriate treatment location, i.e., hospital or non-hospital, for each project.

The bed sizing model results provide the starting point for construction planning, but may be modified to account for factors not included in the model, such as new bed sections, or spinal cord injury beds.

The number of beds planned for three of these construction projects--North Chicago, Augusta and Dayton - were reduced slightly in the VA budget request because of the significant observed reductions in VA's length of stay that have occurred since projects were initially sized. The reductions are attributable to the impact of DRG-based funding and other management improvements. In addition, average occupancy rates are estimated to decline by over nine percent since these projects were initially planned.

FY 1986 SEQUESTRATION

QUESTION:

1. In your February 5, 1986, response to Representative Shelby, the Chairman of the House Veterans' Affairs Committee's Subcommittee on Housing and Memorial Affairs, you discussed how the VA's estimate of guaranteed loans for FY 1986 was made and stated that the agency's "current thinking" is that the VA will far exceed the estimates for FY 1986 from which mandated reductions must be made pursuant to the President's February 1 sequestration order under Gramm-Rudman. Specifically, you noted that, without the limitation imposed by the President's order, the VA estimated that it would guarantee approximately 270,000 loans amounting to $18.2 billion during FY 1986.

1A. In light of this re-estimate, what do you now estimate that the total amount of loan guarantee fees will be in FY 1986 (i) in the absence of sequestration, or (ii) if sequestration occurs, under a loan guaranty limitation amount of $17.4 billion ($18.2 billion reduced by 4.3%)?

1B. (i) Does the $18.2 billion figure include direct loans sold by the VA with a guaranty?

(ii) [If so] How much of the $18.2 billion is accounted for by such loans?

1C. The Director of the Congressional Budget Office, in his February 5 letter to Representative Shelby, stated that direct loans with guaranties are not "subject to sequester". Do you agree that these loans are not subject to any limitation under Gramm-Rudman? Please explain your conclusion.

1D. (i) Does the VA's re-estimate of loan activity in FY 1986 have any implications for the accuracy of the estimate of loan activity used for making FY 1987 projections in the VA's budget documents?

(ii) [if so] Please provide a detailed explanation of the implications and an FY 1987 re-estimate.

Response:

1A(i). We estimate approximately $178.4 million would be collected in funding fee income on guaranteed loans in the absence of sequestration in FY 1986.

1A(ii). If sequestration were to occur, under a loan guaranty limitation of $17.4 billion, we project revenue generated from the collection of funding fees on guaranteed loans would be about $170.5 million during 1986.

1.B. The VA estimate of loan amount does not include direct loans sold with a guaranty. Public law 99-177 sequestered new loan guarantee commitments and did not sequester direct loans sold by the VA with a guaranty.

1.C. Yes, in fact the loan guaranty base used in the sequestration process does not include direct loans.

1.D.(i). The 1987 projections were made at the same time using the same basic assumptions that were used in making the 1986 estimate. Since that time there has been a decrease in the interest rates(provided by VA) to 9.5%. If interest rates stay at this level or in fact go lower this would have an impact on the 1987-1991 budget level.

1.D.(ii). The 1987 estimate of loan volume was formulated when the maximum VA mortgage rate was 12.5 percent. Later in the budget process mortgage interest rates decreased to 11.5 percent. VA's estimate of loan volume did not contemplate a decline to the current rate of 9.5 percent (the lowest level in seven years). If the rate remains at this level, or drops even lower, the VA should continue to experience higher than projected loan volume. The 1986 base estimate (prior to sequestration) has been increased by Congress to $18.2 billion. It is felt that the 1987 guaranteed loan volume could be even higher. However, the VA is currently reviewing this program to determine revised estimates based upon the decline in interest rates and increased program activity. The revised projection should be available shortly.

QUESTION:

2. A. In implementing the President's February 1, 1986, order providing for sequestration effective March 1, 1986, will the VA make reductions in educational assistance and rehabilitation subsistence allowance payments effective with respect to all payments made on or after March 1 or only to payments made for periods beginning on or after that date?

B. In implementing that order with respect to burial and plot allowances and headstones and markers, will reductions be made with respect to deaths occurring after March 1; claims submitted after March 1; payments after March 1; or some other alternative?

C. How will the effective date for reductions in specially adapted housing and adaptive automobile assistance grants be implemented?

D. Will any VA benefit payments made after September 30, 1986, be reduced as the result of the implementation of the President's February 1 order?

RESPONSE:

2.A. The reduction in the payments of Chapter 34/35 educational assistance allowance benefits and Chapter 31 subsistence allowance benefits will be made for education and training for which funds are obligated during the period March 1 through September 30, 1986.

2.B. Claims which are finally adjudicated on or after March 1 will be paid at a reduced amount. There will be instances, however, when claims received prior to March 1 cannot be cleared before the cut-off. This situation will most often arise when evidence needed to support the claim was requested but did not arrive before March 1.

2.C. All claims for automobile grants which are finally adjudicated on or after March 1 will be paid at a reduced amount. Similarly, all claims for reimbursement for adaptive equipment which are approved on or after March 1 will be granted at a lower amount.

With regard to specially adapted housing, a notice will be placed in the Federal Register announcing that grant funds obligated on or after March 1, 1986, for specially adapted housing and special housing adaptation will be reduced by eight per cent from the amount calculated using the the appropriate formula.

2D. In those benefit programs where payment for the proceeding month is made on the first of the next month, the payment for the month of September will be at the Gramm-Rudman levels. For the non-recurring payment programs, because of the approximately 10-day delay between the approval of a VA benefit claim and the actual issuance of a check by the Treasury Department, there will be individuals who will receive a check after September 30 at the reduced Gramm-Rudman rate. All benefit claims adjudicated after September 30 will be paid at the higher amount.

Question: 3.a. Will payments under section 903 of title 38, United States Code, for burial and funeral expenses and transportation costs for certain veterans who die in VA facilities be reduced under the February 1, order?

b. (If yes) Please describe how the effective date will be implemented.

c. (If no) Please provide an analysis explaining why the February 1 order does not apply.

Answer: The sequestration order is applied to activities. Burial of the dead is a component of the Miscellaneous Benefits activity. While the Miscellaneous Benefits activity will receive its share of the sequestration, funding for burial, funeral expenses and transportation cost will be maintained at an appropriate level to continue these services.

Question: 4. What will be the impact of sequestration on the level of medical care funds available for contract care, including for such care in non-contiguous States pursuant to section 601 (4) (c) (v) of Title 38, United States Code?

Answer: The sequestration reduced all non-VA (contract care) direct by 1 percent. The reductions to non-VA programs are as follows:

Contract Hospital.	$1,399,000
Community Nursing Home . .	2,784,000
State Homes.	681,000
CHAMPVA.	825,000
Total sequestration. .	$5,689,000

We expect no adverse effect on our ability to provide contract care to veterans and will request reprogramming from other Medical Care activities if that becomes necessary.

FEBRUARY 21, 1986

1. With respect to the proposal to declare excess and dispose of certain parcels of land at two VA Medical Centers in California -- West Los Angeles and Sepulveda -- I note that their surveys completed by the General Services Administration upon which the recommendations to excess these parcels are based were more than 3 years old.

Question: 1A. When did the VA receive them?

Answer: The GSA survey reports for West Los Angeles and Sepulveda were received on January 3, and January 10, 1986 respectively.

Question: 1B. What accounted for the delay in the furnishing of these surveys to the VA?

Answer: We are advised by GSA that the Federal Property Review Board (PRB) requested that the surveys be presented for their prior review rather than being submitted directly to VA. The PRB indicated that they would transmit the surveys to VA. GSA submitted the surveys to the PRB in April 1983. The PRB was subsequently disbanded. GSA followed-up by reverifying the survey contents in October 1985; after which, the results were forwarded to VA.

Question: IC. What were the views of the Directors of the two Medical Centers as to whether the parcels should be declared excess to the VA's needs?

Answer: The local hospital directors agreed with portions of the GSA survey reports.

Question: 1D. What were the views of the District and Regional Director?

Answer: The District and Regional Directors agreed with portions of the GSA survey reports.

Question: IE(i). Everett, is it your position that the parcels of land in question are no longer needed by the VA in carrying out its functions?

Answer: I completely support the President's proposal to raise revenues from the sale of excess VA property. In order to implement this policy, determinations have to be made concerning what particular pieces of VA property are no longer needed for current or future use. As you know, I have provided the required Congressional notification of my intention to declare certain land and improvements excess to the agency's needs. A VA team has been sent to survey the land in question to look at its current and future uses. Even if any adjustments have to be made as a result of this survey, I believe that there is sufficient excess property available in the VA system to meet the President's objectives. I am sure that the President's goal can be met.

Question: IE(ii). (If NOT) Then I assume that you will not actually declare them to be excess. Is that correct?

Answer: See the response to question 1E(i).

Question: IE(iii). (If YES) (a) During the House Veterans' Affairs Committee's February 6 hearing on the VA's budget, you twice said you agreed "100 percent" with Chairman Montgomery when he expressed opposition to the proposed excessing. What has changed?

Answer: I agreed with Chairman Montgomery to the extent that relocating the Regional Office from expensive office building space to the hospital campus at West Los Angeles is a good idea if there is a savings to the VA. However, in the broader context, relocation of the Regional Office out of federally owned space must be evaluated in terms of its overall cost to the government. Therefore, that statement did not mean that I agree that all of the land in question is necessarily essential to the VA's mission.

Question: 1E(iii)(b). Also during that hearing you indicated that you want to look at the issue further. Have you actually made a formal determination declaring the property excess? Are you reconsidering it?

Answer: I have provided the required Congressional notification of my intention to declare certain land and improvements excess to the agency's needs. A VA team has been sent to survey the land in question to look at current and future uses of the land.

Question: 1E(iii)(c). Are you considering other options for this property, such as leasing or sharing?

Answer: Not at this time.

Question: 1F. In several instances, the GSA surveys note that optimum use was not being made of the parcels in question or that the land is underutilized or not utilized. Are these assertions accurate in 1986?

Answer: The GSA surveys were performed in 1983; however, GSA reaffirmed the surveys in October 1985. A VA team has been sent to survey the land in question to look at current and future uses of the land.

Question: 1G. If the land were not declared excess to the VA's needs, what use would be made of it?

Answer: See response to question 1E(i).

Question: 1H. In the case of the West Los Angeles VAMC, the property proposed to be excessed consists of 4 parcels and a portion of a 5th parcel. Two of those parcels -- parcels 1 and 3 -- were identified by GSA as "not utilized"; one -- parcel 2 -- was considered to be "underutilized"; and two -- parcels 6 and 9 -- were considered as not being put to optimum use. However, the GSA recommended excessing a total of 9 parcels of land at the facility, 5 of which were considered "not utilized". Please explain the VA's reasoning in selecting the parcels it has identified for excessing.

Answer: GSA's original report remains unchanged; however, in preparation for 1987 budget proposals GSA reduced the number of acres recommended to be excessed in order to retain parcels having greater potential future use by VA.

Question: 1I. Why were the other 3 parcels considered to be "not utilized" -- parcels 5, 7, and 8 -- not proposed to be excessed?

Answer: Parcels 5, 7 and 8 are sites having a greater potential for current or future uses by the Agency.

Question: 1J. Please review and provide the Committee with comments on the survey reports at these two facilities - noting in each case changes that may have occurred since the surveys were completed (for example, the weekly average use of the golf course, the status on non-VA uses of parcel 1, and the status of the improvements on parcel 9).

Answer: We would be pleased to provide comments on the updates in the GSA surveys in the near future.

Question: 1K. The GSA survey notes that in the case of 3 of the parcels proposed for excessing "some reservations may be required to protect the interests of the VA and purchasers of selected parcels." Are these reservations (as specified on page 8 of GSA's report) still current? (If not, please provide and update.)

Answer: To our knowledge, these reservations are still current.

Question: 1L. With respect to parcel 9 at the West Los Angeles facility, the GSA's report notes that it "is somewhat close to the new hospital in the south end of the facility; however, permitted uses as established by local zoning would be expected to make any future development compatible with the hospital." What permitted uses do you believe would be established for this parcel?

Answer: See the response to question 1E(i).

Question: 1M. How does this proposed excessing affect plans to expand the national cemetery located adjacent to the West Los Angeles VAMC and to relocate the VA's Los Angeles Regional Office on the grounds of the VAMC?

Answer: Twenty acres of land on the west side of the San Diego freeway, is under the jurisdiction of the Department of Memorial Affairs and previously identified for possible cemetery expansion. Only six of these twenty acres have been identified for excess. The VA's regional office is currently located in a federally owned office building approximately one mile from the medical center. The construction of additional office space would have to be considered in the context of the overall cost to the government for federally owned office space in the Los Angeles Area. The land available after excessing could accommodate the siting of a new regional office building.

Question: IN. In light of the length of time for normal GSA excessing processes and the 180-day Congressional waiting period, as well as the cloud on the title insofar as the West Los Angeles property is concerned, how could a sale take place during FY 1987.

Answer: Revenues from the sale of properties included in the President's Real Property Management initiative are expected to occur over FY 1987 and FY 1988.

LOAN GUARANTY SEQUESTRATION

2. In a February 5, 1986, letter to Representative Richard Shelby, Chairman of the House Committee on Veterans' Affairs' Subcommittee on Housing and Memorial Affairs, the VA advised that the agency's "current thinking" is that, without the limitation imposed by the President's order, the VA would guarantee approximately 270,000 loans amounting to $18.2 billion during F.Y. 1986.

A. Is that your estimate today?

B. As you know, together with Chairman Murkowski, I and 3 other members of this Committee introduced S. 2052, a bill which now has 14 cosponsors and which would raise to $17.6 billion the F.Y. 1986 loan activity level to which the 4.3-percent Gramm-Rudman reduction would apply.

(i) I understand that you now support my bill, S. 2052, is that correct?

(ii) [If yes] Would you similarly support this legislation if the level at which the base from which the Gramm-Rudman reduction would be made were amended to be $18.2 billion?

C. We are making every effort to facilitate the speedy consideration and enactment of S. 2052. In the event, however, that it is for some reason not enacted -- and if, as you have indicated, the VA does not proceed on March 1 with the proposed means of achieving the reduction required in this program as it was announced in your February 6 press release -- what actions would the VA take to enforce the Gramm-Rudman cap?

Response 2 (A-C): On March 7, 1986, the President signed Public Law 99-255. This law in effect increased the base estimate for new guaranteed home loans from $12.1 billion to $18.2 billion. This reflects the Agency's current estimate of loan activity in the absence of sequestration. This loan amount corresponds to a workload level of 270,000 guaranteed loans. It should be remembered that this action only increased the pre-sequestration base. The limitation after the 4.3% reduction will be established at $17,417,400,000. As a result, the previously announced action of closing the loan guaranty program on April 1 will not occur. Since the law basically corrected the estimate used in the budget, some steps may be required to assure the operation of the program through the fiscal year.

Other Sequestration Issues

Question: 3. When will the VA formally announce in the Federal Register the reductions it is making in various benefits under Gramm-Rudman?

Answer: The announcement for the Federal Register has been drafted and is in the final review process within the Agency.

Question 4: With respect to the grant programs under which certificates of eligibility are issued to veterans--specially adapted automobile and specially adapted housing programs--and the proposed reductions in the levels of assistance under such programs, how will the VA implement the effective date of the reductions required by Gramm-Rudman?

A. Specifically will the reduction apply to all grants actually made after March 1, or to only grants based on certificates of eligibility issued after that date?

B. (If applicable to all grants made after March 1) How will the VA advise veterans of the fact that their certificates are reduced in value?

Response 4.A. Regardless of when the Certificates of Eligibility were issued, all payments for automobiles as well as payments for reimbursement for adaptive equipment for automobiles, which are authorized on or after March 1, will be paid at the lower amount. With regard to specially adapted housing, funds obligated on or after March 1, will be paid at the reduced amount.

Response 4.B.: Notice of these payment reductions will be published in the Federal Register. In the case of automobiles and specially adaptive equipment, notification that the payment has been reduced as a result of the Balanced Budget and Emergency Deficit Control Act of 1985 will also be issued with the payment. With regard to specially adapted housing, a letter will be sent notifying the recipient of the reduction in the calculation once the specially adapted housing grant has been approved.

Question 5: It is my understanding that the VA has, in order to achieve the reductions required under Gramm-Rudman, suspended advance payments of educational allowances under the GI Bill and of subsistence allowances under the VA's vocational rehabilitation program.

A. Please provide an analysis of the legality of suspending such payments in light of the fact that section 1780(d)(2) of Title 38 states that "an eligible veteran or eligible person shall be paid an educational assistance allowance or subsistence allowance ..advance payment." (Emphasis added)

B. How much is it estimated that suspending advance payments will save in fiscal year 1986 and, if such payments were not suspended, what would the impact be on levels of assistance under the GI Bill and vocational rehabilitation programs?

C. What are the increased administrative burdens and associated costs to the VA of suspending advance payments of these educational-assistance benefits and subsistence allowances?

D. What other administrative adjustments, if any, has the VA made in order to achieve the mandated reductions in the GI Bill and vocational rehabilitation accounts?(Please describe any such adjustments in detail.)

Response 5 (A): Advance payment processing was temporarily suspended in an attempt to avoid creating overpayments against veterans' accounts occasioned by reductions mandated by Public Law 99-177. After reflection and review, it was determined that this action was not correct, and action has been taken to resume advance payments. Veterans who were entitled to advance payments, but did not receive them as a result of the suspension, will receive benefits on the regular payment schedules. Hardship cases will be alleviated by out-of-system payments.

(5.B.) The suspension action was not taken in order to generate savings but, rather, at the time it was thought to meet the sequestration order of the President under Gramm-Rudman.

(5.C.) Since we are reinstating advance payments, there are no increased administrative burdens and associated costs to the Veterans Administration.

(5.D.) No other administrative adjustments have been made in order to achieve the mandated reductions in the GI Bill and vocational rehabilitation accounts.

Question: 6. Under Gramm-Rudman, the FY 1986 cut in the VA's medical care account was limited to one percent, except that administrative expenses were required to be cut by 4.3 percent. As a result, $760 million was identified as the amount of FY 1986 administrative expenses and 4.3 percent of that amount, or $32.68 million, was sequestered.

6.A. Please describe the criteria that were used to detetmine what expenses were administrative expenses for this purpose and provide a listing of those expenses.

Answer: The administrative support section of the VA Cost Center Report RCS-MPO-98 for fiscal year 1985 was used as the basis for determining the administrative costs. The total administrative costs shown on this report for 1985 were $1,144,033,987. From this report the following cost centers were selected as being those applicable to the administrative cost provision of the Gramm-Rudman Act:

MEDICAL CARE

ADMINISTRATIVE COST BASE FOR GRAMM-RUDMAN

Description	CC	Total Cost 1/
Office of Dir, & COS	8401	$268,269,877
ADP	8402	52,317,129
Coordination of VA Trng. Prog.	8403	18,438,054
Multi-Level Care Project	8404	345,211
Eval. of Prevent. Hlth.-Care Svc.	8406	33,081
Contractual & Fee Svc Section	8413	16,564,340
Medical Info. & Records Section	8414	79,462,669
Office Operations Section	8416	148,170,314
Fiscal	8421	67,451,048
Personnel	8431	64,495,150
Cent. Safety & Fire Protec. Eng.	8461	1,330,917
Med Medicine Prd Services	8225	15,922,795
Libraries	8226	27,937,994
Total		$760,738,579

1/ 1985 actual costs

Question: 6.B. What criteria did the VA propose to OMB to be used for this purpose?

Answer: The effort to determine the administrative expenses was a joint effort between VA and OMB.

Question: 6.C. What amount did the VA recommend to OMB be considered as administrative expenses?

Answer: Not applicable see answer to question (B).

Question: 6.D. Do you disagree with any of the categories of administrative expenses that are included in the $760 million amount?

Answer: The Agency concurred with the individual categories of administrative expenses in the $760 million.

Question: 6.E. If in FY 1987 or a later year a sequestering of 15 percent or more of administrative expenses were required, what difficulties would such a cut present in administering VA health-care programs reduced by only 2 percent?

Answer: Non-exempt administrative costs (in areas such as medical administration, personnel and fiscal) include essential back-up support in providing clinical care. Unrealistic reductions in administration costs could force reductions in clinical areas that may exceed 2 percent.

Question 7: The amount of readjustment benefits account FY1986 budget authority that has been sequestered is $39,431,000, which is a 4.3% of $917 million. However, only $826 million has thus far been appropriated to that account for 1986. The Administration is submitting a $91 million supplemental request for this account, and that would bring the total to $917 million, the amount on which the sequestration was based.

A. What is the statutory authority for the February 1 order sequestering a percentage of budget authority that had not been enacted as of this date?

B.(i). If a $91 million supplemental appropriation for the readjustment benefits is not enacted--or a smaller amount is enacted in its place--how will the then incoreectly sequestered amount be restored?

(ii). Would the funds that had been incorrectly withheld from individual veterans be restored?

Response 7. (A): The base amounts used for the sequestration process were determined jointly by OMB and CBO based upon the Gramm-Rudman bill. The statutory authority used in their determination was section 251 (a)(6)(A)of Public Law 99-177. Basically this section states that the budget base used in the sequestration process will "assume the continuation of current law in the case of revenues and spending authority as defined in section 401(c)(2) of the Congressional Budget Act of 1974." The $917 million estimate reflects the appropriated resources necessary to pay the Title 38 rates to eligible persons in 1986 prior to sequestration. It was from this base that the sequestration amount was taken.

B(i-ii): It is important to note that the sequestration of funds and the supplemental request are two different actions. The supplemental request of $91 million is necessary to meet the funding requirements at the reduced payment rates for the projected 1986 workload. The sequestration process was an attempt to reduce rates in order to achieve saving levels targeted in P.L. 99-177. As mentioned in the previous response, the base amount correctly reflects the funding needs under the continuation of current law for entitled benefits. If the supplemental is not provided, it will be necessary to stop making payments to entitled individuals. It should be noted that this would be a result of not receiving adequate funding, as it would in any year a required supplemental for an entitlement program is not provided, and not the result of the sequestration of funds in 1986.

Question: 8. What is the effect on the FY 86 deficit of sequestering $8,104,000 in the Canteen Service Revolving Fund.

Answer: P.L. 99-177 requires that offsetting collections be included as sequesterable budgetary resources. The intent of the law is to maintain revenues, while reducing obligations, therefore increasing revenues to be paid into the Treasury. Based on initial estimates of collections, $8,104,000 in obligations will be sequestered in 1986.

The VA is developing plans to reduce obligations. The plan will maintain the best services to veterans and will attempt to maximize revenues while meeting the mandated reductions in obligations. Still, some loss of revenue is expected to occur. Prior to P.L. 99-177 the Canteen Service was expected to generate a profit of $3,000,000 in 1986. Currently, due to the law, profits may drop to the $1,500,000 level.

Question: 9. On page 5-22 of the VA's budget documents, a proposed increase of $4 million is proposed in connection with providing funding at 10 VA medical centers to support contracts with non-VA adult day health care centers.

A. Which 10 VAMCs are proposed for this funding?

Answer: The VAMCs will be selected from respondents to a solicitation of those VAMCs indicating a need for this program in MEDIPP and having community ADHCs available which meet VA standards and are willing to provide services to veterans by contract.

Question: B. Which 8 VAMCs are currently operating in-house ADHCs?

Answer: The following eight VAMCs are currently operating in-house ADHCs: Brooklyn, NY; Butler, PA; Little Rock, AR; Miami, FL; Minneapolis, MN; North Chicago, IL; Palo Alto, CA; and Portland, OR.

Question: C. What level of funding is proposed to carry out the evaluation of the ADHC program as mandated by Public Law 98-160?

Answer: Health Services Research resources of $1,100,000 and 25 FTEE are requested for the evaluation (page 6-20).

Question: D. What entity will carry out that evaluation?

Answer: The Health Services Research and Development Service will conduct the evaluation with the consultive assistance of the Director, Patient Treatment Service, Office of the ACMD for Geriatrics and Extended Care.

Question: 10. At which VA facilities are the 59 hospital beds which (as stated on page 5-17 of the VA's budget documents) are proposed for conversion to nursing home care beds?

Answer: There are two facilities with nursing home bed conversions planned in 1987; Batavia, NY with 25 beds and Buffalo, NY with 34 beds.

Question: 11. On page 5-21 of the VA budget documents, an increase is described of $1.8 million and 69 FTEE in connection with the National Disaster Medical System.

A. Which VA medical centers have been designated to serve as National Disaster Medical System Coordinating Centers?

Answer: The following VAMCs have been designated as National Disaster Medical System Coordinating Centers:

REGION 1 (12)

Albany, NY
Batavia, NY
Brooklyn, NY*
Bronx, NY*
Buffalo, NY
Canandaigua, NY
Castle Point, NY*
Manhattan, NY*
Montrose, NY*
Northampton, MA
Northport, NY*
Syracuse, NY*

REGION 5 (3)

Des Moines, IA
Minneapolis, MN
Wichita, KS

REGION 2 (4)

East Orange, NJ*
Lyons, NJ*
Pittsburgh, PA*
Salisbury, NC

REGION 4 (3)

Allen Park, MI*
Cleveland, OH*
Indianapolis, IN

REGION 6 (1)

Portland, OR*

REGION 3 (6)

Atlanta, GA*
Birmingham, AL
Jackson, MS
Lexington, KY
Louisville, KY
Nashville, KY

REGION 7 (7)

Little Rock, AR
New Orleans, LA
Shreveport, LA
Houston, TX*
Oklahoma City, OK
Albuquerque, NM
Tucson, AZ

**Denotes Present VA/CMCHS Coordinating Center

Question: B. Will the health system specialists assigned as coordinators and as program assistants at those centers work full-time in that capacity?

Answer: The health system specialists assigned as coordinators and program assistants will serve full-time in those capacities.

Question: C. What will be the GS-level and qualifications of the coordinators and program assistants?

Answer: GS levels - coordinators GS-12/13

program assistants GS-5/6

Functional description - a. Preparation of a joint Military-VA-Civilian Operations Plan for the designated primary receiving area; b. Reception, sorting and provision of emergency care to patients at the arrival point; c. Planning and transportation of patients from arrival location to appropriate military, VA and civilian hospitals; d. Administrative responsibility for military casualties hospitalized in non-military facilities (military assistance will be required); e. Submission of bed availability reports for civilian and VA hospitals to the Armed Services Medical Regulating Office (ASMRO); f. Maintenance of a military patient locator system; g. Provision for military personnel management for all military personnel hospitalized within the area. (DoD assistance will be required); h. Maintenance of liaison with participating civilian hospitals; i. Implementation of annual exercise to test the area operation plan; j. Responsibility for successful area participation in the CMCHS continuing education program.

Question: D. (i) who at Central Office will coordinate this program?
(ii) To whom will this person report?

Answer: i. Field program coordination will be the responsibility of Anthony Ilardi, Program Manager, Emergency Management and Resource Sharing Service (10B/EMS), Grant A. Dillon, Acting Director.

ii. The Director, Emergency Management and Resource Sharing Service (10B/EMS) reports to Robert E. Lindsey, Jr., Director for Operations (10B).

Question: E. Will the designated medical centers be forced to absorb any FTEE or other costs in order to serve as coordinating centers?

Answer: The designated VA medical centers will not be expected to absorb any FTEE or other costs in order to serve as coordinating centers.

Burial Benefits

Question

12A. If eligibility for the plot allowance were restricted as you propose, what would be the impact on the conduct of veterans' mortality studies by, for example, the National Academy of Sciences (which currently depends on the mortality data in BIRLS developed in substantial part through the payment of the plot allowance)?

Response

12A. Only the National Academy of Sciences can determine the impact the proposed legislation will have on any of their studies. We can state that the plot allowance program has not been totally successful as a vehicle for obtaining death certificates. Our statistics indicate that we are not getting the same percentage of death certificates we were getting before the burial allowance criteria were changed in 1981.

Question

12. B. What would be the impact on the attractiveness of states of establishing state veteran's cemeteries:

Response

While it is true that this proposal would involve the loss of some resources of the States, based on their lack of participation in the program under current law, and the fact that no plot allowances are currently paid for spouses, this change is likely to have a minimal effect on program participation.

VA Insurance Operations

Question

13. On February 3, Senator Burdick wrote to the VA to express his concerns regarding the proposal to consolidate certain activities of the VA's Insurance operations. Please provide to me directly and for the record a copy of your response to his letter.

Response

13. A copy of the Agency's response to Senator Burdick is attached.

Administrator
of Veterans Affairs

Veterans
Administration

FEB 26 1986

Honorable Quentin N. Burdick
United States Senate
Washington, DC 20510

Dear Senator Burdick:

Thank you for your recent letter concerning VA Insurance operations. On February 5, 1986 in accordance with Section 210 (b), title 38, United States Code, I submitted to Congress the enclosed Veterans Administration study plan to consolidate all Insurance activities at the Philadelphia, Pennsylvania Insurance Center. I would like to take this opportunity to share with you the reasons for my decision to combine the St. Paul, Minnesota and Philadelphia, Pennsylvania Insurance functions at the Philadelphia Office.

Since 1951, the Veterans Administration's Department of Veterans Benefits (DVB) has consolidated the number of its Insurance Offices from thirteen to the present two offices. These consolidations have been possible because of the decline in active policies after the National Service Life Insurance (NSLI) and the United States Government Life Insurance (USGLI) programs were closed to new issues, as well as the impact of normal policyholder mortality. Technological advances in data management and record keeping have also allowed us to administer the Insurance programs in a more efficient manner, with fewer resources.

In order to achieve further savings, an independent staff office, the Office of Program Analysis and Evaluation (OPA&E), was asked to study the feasibility and potential savings of consolidating the two remaining Insurance Offices into one. In their study, OPA&E considered the savings of a merger in St. Paul as well as in Philadelphia. The analysis concluded that there would be significant savings by a phased consolidation of the Insurance activities in Philadelphia. Specifically, the study concluded that the relocation will save $1.29 million per year ($7.74 million over a six-year operational life cycle) primarily through the reduction of clerical and supervisory overhead. The study also indicated that we will be able to eliminate 38.4 full-time equivalent positions and the consolidation will reach the break-even point by June 1988 if begun in October 1986.

We believe that the phased-in approach will allow us to complete the move without significant disruption to employees or to the delivery of Insurance benefits. Therefore, commencing October 1, 1986, we plan to move the Insurance functions currently performed at the St. Paul Insurance Center to Philadelphia in several phases to ensure program continuity. While the study is framed in terms of an April 1986 starting date for the phased reorganization, no action to begin implementation will be taken prior to October 1, 1986.

All employees assigned to the Insurance function at St. Paul will be offered the opportunity to transfer to Philadelphia. Due to the significant distance between the two Insurance Centers, it is difficult to estimate the actual percentage of employees that will move from St. Paul to Philadelphia. We will do everything feasible to make the relocation as easy as possible for those who choose to move. If a number of employees choose not to transfer to Philadelphia, Reduction in Force (RIF) authority will be required to implement the proposed consolidation. For those not accepting relocation, employment assistance will be provided through coordination with all other Federal Agencies in the Minneapolis-St. Paul area.

In response to the specific issues contained in your letter regarding employee pay scales, space rental fees, and relocation costs, the following information is offered. As of December 31, 1985, the average employee's grade level at the Philadelphia Insurance office was 5.39 while at St. Paul the average grade level was 6.55. The Philadelphia office is a government owned facility, rather than commercially rented space. The enclosed study plan indicates that the cost per square foot at St. Paul is $13.50 compared to $7.58 at Philadelphia. The cost of completing the consolidation of facilities will be absorbed by the Department of Veterans Benefits general operating expenses appropriation.

I thank you for allowing me to provide this information to you, and assure you that the consolidation of all Insurance functions at the Philadelphia Insurance Center will help the Veterans Administration meet its goal of providing quality service to veterans and their beneficiaries at the lowest possible cost to the taxpayers.

Sincerely,

Everett Alvarez Jr.

EVERETT ALVAREZ, JR.
Acting Administrator

Enclosure

WRITTEN QUESTIONS FROM SENATOR SPECTER TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

Question: 1. The Veterans Administration is facing two trends which indicate the need for at least maintenance of the current level of veterans' health care. On the one hand, there is an aging veterans' population which will increasingly need the services provided by VA Medical Centers. On the other hand, there are several hospitals still in the VA system built before WWII or shortly thereafter which have not adapted to the great strides in medical technology made in recent years.

What proposals is the VA considering to address these issues, especially in light of the proposed reductions in the construction, health care, and medical personnel budgets?

Answer: The current VA philosophy is to continue to provide quality medical care with the least possible expenditure of resources. Under the Medical District Initiated Program Planning (MEDIPP) process, the identification of specific needs is accomplished on the basis of an extensive mission assessment by each medical center in the medical district. The provision of those needed services, however, is centered on a medical district as opposed to individual medical centers. It is not necessary, nor is it cost efficient, for each medical center in a medical district to possess every piece of current medical technology, or every specialized medical program. If one medical center proves to be the most efficient location for a technology or specialized service, it will be proposed for that medical center despite the age of the facility.

QUESTION 2. The proposal to raise the Home Loan Guaranty Program loan origination fee from 1% to, ultimately, 3.8% has raised legitimate concern within the veterans community that it would reduce revenue by decreasing the demand for such loans, thereby depriving many veterans of the opportunity to buy homes. How do you answer this charge?

Response: An increase in the funding fee will eliminate some veteran participants who either can not afford the fee or choose not to pay it. However, an increase in the fee is necessary to provide a reserve for future expenditures.

QUESTION 3: What impact do you project failure to renew the highly successful New GI Bill will have on armed services recruitment?

RESPONSE:

The Veterans Administration defers to the Department of Defense on the impact of the education incentives on recruitment and retention. We understand that the DOD has already supplied data supporting its conclusions of the cost-effectiveness and incentive aspect of this program to both the House and Senate Veterans Committees.